Extending Independent Nurse Prescribing within NHSScotland

A guide for implementation

Scottish Executive Health Department
HOW TO USE THE GUIDE

This guide has been prepared for:

- Acute Trusts
- Primary Care Trusts
- Personal Medical Services Pilots
- LHCCs
- General Practitioners
- NHS Boards
- Higher Educational Institutions providing nurse education

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

- Trust Nurse Prescribing Leads
- Existing Nurse Prescribers
- Community Pharmacists
- Community Services Pharmacists employed by, or contracted to, NHS Trusts
- Patient Groups

It will be for Primary Care and Acute Trusts, and NHS Boards, to decide, in light of local priorities and in consultation with 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.

All or part of the guide may be reproduced at local level for the information of individual nurses or other interested parties, as required.
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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 Scotland

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. Implementation of nurse prescribing was piloted in England in 1994 and followed by its introduction in the other UK countries. The necessary legislation to enable community nurses in Scotland with either a district nursing or health visiting qualification to prescribe independently from a limited formulary was passed in 1996.1

3. The scheme was introduced in Scotland by a phased implementation, which commenced in 1996 and is now complete. It enabled all practising district nurses, health visitors, and practice nurses with either qualification to undertake a course of preparation approved by the former National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS) (Now NHS Education for Scotland (NES)) for independent prescribing from the Nurse Prescriber’s Formulary. This comprised a stand-alone course of 2 days attendance preceded by a period of open learning.

4. Since 1999, preparation for prescribing from this formulary has been included in the district nursing and health visiting pathways of specialist practitioner programmes. Prescribing is now integral to the role of all district nurses, health visitors and the small number of practice nurses who have successfully completed the assessment requirements of either the stand alone or integrated course and whose prescribing status is noted on the Professional Register held by the Nursing and Midwifery Council (NMC). There are approximately 3000 nurse prescribers in Scotland today.

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1 The Medicinal Products; Prescription by Nurses, etc, Act 1992 (Commencement (No. 2) Order) 1996; and The National Health Service (Pharmaceutical Services) (Scotland), (General Medical Services) (Scotland), and (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 1996.
Extending nurse prescribing

5. 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.

6. 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.

7. 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 the NHS (General Medical Services) (Scotland) Regulations, with the exception of those products which contain controlled drugs, together with a list of Prescription Only Medicines (POMs). £2 million of central funding is allocated over the period 2001-2004 to train an additional 1500 nurse prescribers.

8. 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 thought to be particularly suitable for nurses working with patients with enduring conditions such as asthma, diabetes, heart disease or mental illness. A consultation document issued in April 2002 states nurses and pharmacists will be the first professionals involved in supplementary prescribing.

Current nurse prescribers

9. District Nurses and Health Visitor prescribers will continue to be able to prescribe from the current Nurse Prescribers’ Formulary, which 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

10. This guidance sets out the steps to implement extended nurse prescribing in Scotland. The legislation that permits the extension of prescribing applies across the UK, and Ministers in Scotland have decided that extended nurse prescribing will be implemented.

WHO MAY PRESCRIBE AND WHAT MAY BE PRESCRIBED IN EXTENDED NURSE PRESCRIBING

Categories of nurses and midwives who may prescribe

11. Amendments to the Prescription Only Medicines (POM) Order, NHS (Pharmaceutical Services) (Scotland) Regulations, NHS (Charges for Drugs and Appliances) (Scotland) Regulations, came into force on 1 April 2002. This means that it is not 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.

12. Under the provisions of the amended regulations, to be legally eligible to prescribe from the Extended Formulary:

(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 NMC professional register with an annotation signifying that the nurse has successfully completed the specific programme of preparation for extended nurse prescribing approved by NHS Education for Scotland (previously National Board for Nursing, Midwifery and Health Visiting for Scotland), and is qualified to order medicines and medical devices from the Extended Formulary.

Nurse Prescribers’ Extended Formulary and the Scottish 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 Nurse Prescribers’ Formulary (NPF). The list will be published quarterly in the Scottish Drug Tariff and incorporated every 6 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 6 months. The NPF 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 Scottish Drug Tariff will be supplied to all nurse prescribers every 6 months through Information
and Statistics Division of the Common Services Agency (ISD). These publications will be alternated so that nurses receive either a BNF or a Scottish Drug Tariff every 3 months. Nurse prescribers should have access to an up-to-date copy, if required. The Nurse Prescribers Formulary is given in part 8B of the Scottish Drug Tariff. The Nurse Prescribers Extended Formulary will be published as part 8C.

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, where these apply to other prescribers. In prescribing as in other areas of practice, nurses and midwives are bound by the NMC Code of Professional Conduct 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 and administration of named 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 3 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, confirmation of access to a prescribing budget
    on completion of the course;
  – they will be able to access continuing professional development (CPD)
    opportunities on completion of the course.

19. There are likely to be many nurses in any local health system 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.

Central funding for extending nurse prescribing

21. Central funding will be made available to train nurses in prescribing. This will be
allocated on the basis of named lists of nurses Trusts’ have prioritised for training.
The Scottish Executive will also take account of remoteness and rurality issues
when allocating funding. Central funding currently includes a contribution to other
costs, in addition to the course fees. However, this funding is not guaranteed, and
depends upon the fees set by Higher Education Institutions.

22. 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, Acute Trusts, GP
practices, and Personal Medical Services pilots, amongst others) can therefore be
funded from this resource.

Non-NHS staff

23. 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.
24. 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 interest that may subsequently arise in the nurse’s practice. Nurses are reminded 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

25. 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 48 re non-NHS nurses using NHS community pharmacy dispensing services.

EDUCATION AND TRAINING

The programme of preparation for extended nurse prescribing

26. Nurses, midwives and health visitors preparing for extended nurse prescribing will undertake a specific programme of preparation at degree level (Level 3). The programme will include the equivalent of 25 days’ theory plus 12 days’ ‘learning in practice’, when a designated prescribing practitioner (currently a medical practitioner) will provide the student with supervision, support and opportunities to develop competence in prescribing practice. The 12 days refers to the nurse’s time rather than the doctor’s. More details are at Annex C. An additional element of self-directed learning will also be needed, but this does not increase the length of the programme.

27. The programme will be part-time over a minimum period of 3 months: NES recommends the maximum duration should be no longer than 6 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.

28. 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 extended nurse prescribing.

29. The standards for the preparation for extended nurse prescribing have been set out by the NMC.\(^2\) 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.

30. An outline curriculum for the preparation for extended nurse prescribing was published by NES in November 2001. 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.

31. NES will approve the specific programmes of preparation proposed by Higher Education Institutions, which meet the requirements of the NMC. Nurses can only qualify to prescribe by attending an NES-approved nurse prescribers’ programme of preparation.

**Other training and education**

32. Although many universities, and some pharmaceutical companies, offer training and education in aspects of pharmacology and medicines management, only NES-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 prescribing from the Extended Formulary may accredit the nurse prescriber’s prior learning.

**Continuing Professional Development (CPD)**

33. 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 from 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 and updating will need to be incorporated by the individual into their personal professional profile, in order to renew their registration with the NMC. The Scottish Executive Health Department is in contact with the National Prescribing Centre in England about its programme of CPD support for nurse prescribers.

34. 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.
35. 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. SEHD is looking at how 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 document is available on the NPC’s website www.npc.co.uk

Notification of qualification to prescribe to NMC

36. Once the nurse or midwife has successfully completed the prescriber preparation, the NMC will be notified by the NES. The individual’s entry on the NMC professional register will be annotated to indicate that she/he has qualified as a nurse prescriber for extended nurse prescribing. 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 NMC Voice Bank telephone line will confirm to any enquirer whether or not a nurse is eligible to prescribe, and from which formulary: district nurses and health visitors or from the Extended Formulary.

NMC Voice Bank Enquiries

37. Callers will need to state the nurse prescribers PIN and date of birth otherwise they will have to speak to a manual operator when they access the system.

The telephone number is 020 7631 3200
The caller code for pharmacists is: 990159
The pass number is: 6390
The code number is 20
V100 is DN/HV prescriber
V200 is Nurse Prescriber Extended Formulary

ACTIONS FOR EMPLOYER

Notification of qualification to prescribe by nurse’s/midwife’s employer

38. The Higher Education Institution will advise the individual’s employer of successful or unsuccessful completion of the prescribing programme. For nurses successfully completing the programme, the employer is then advised to take the following actions.

39. Nurse employers; PCTs or Island Health Boards, will be required\(^a\) to inform the Primary Care Information Group of the Information and Statistics Division (PCIG/ISD) of the nurse prescriber’s details using the proforma in Annex A.

\(^a\)Under the terms of Paragraph 8 of Schedule 2 to the NHS Act 1990.
40. There is no requirement for PCIG/ISD to be informed of hospital-based nurse prescribers. *GP Practice and PMS Pilots*: these employers should pass details to their Primary Care Trust or Island Health Board, where applicable within 48 hours (excluding weekends or Bank Holidays) of receiving notification of a nurse’s qualification to prescribe. The Primary Care Trust will then be responsible for informing the PCIG/ISD of GP practice and PMS nurse prescribers using the proforma at Annex A. PCIG will continue in their existing role of assigning prescribers codes to nurse prescribers.

41. Briefly, the nurse details to be provided on the proforma include:

- Name
- NMC number
- Qualifications (DN/HV or Extended Formulary Prescriber)
- Practice
- Employer details.

42. Trusts notifying PCIG/ISD of new nurse prescribers who work across more than one practice will be required to provide details of the practice within which the nurse is expected to issue the majority of their prescriptions (i.e. their 'principal prescribing practice'). These nurses will receive one prescription pad pre-printed with the prescriber code for this practice and one prescription pad with the prescriber code left blank to cover any additional practices. See also para 51.

*Notification of change of nurse prescriber details*

43. Trusts should notify PCIG/ISD of changes of circumstances or personal details of nurse prescribers using the proforma in Annex A. 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), the PCT should inform PCIG/ISD as soon as possible.

44. 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.

NHS Boards 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

**Obtaining prescription forms for nurse prescribers**

45. NHS Board, PCT, practice or PMS pilot nurses must be registered with PCIG/ISD before prescription forms can be issued. Early notification of such details is very important in order that qualified nurses can begin utilising their new skills. Prescription pads of GP10N forms will be printed and sent out to Trusts after notification of a new nurse prescriber or newly qualified nurse prescriber. Subsequent supplies of GP10N forms will not automatically be sent out and should be re-ordered from the address below by the Trust.

46. Managers of hospital-based nurses should order HBPN forms, which will be supplied ready for hand stamping with nurse and hospital details. See para 52 for details of stamps required.

47. GP10N or HBPN prescription forms can be ordered from Practitioner Services Division (PSD) at the following address: Moira Gardner, Room D091, Trinity Park House, South Trinity Road, Edinburgh EH5 3SE. Prescriptions are normally sent to the address of the person who orders them (an alternative address can be specified for invoicing purposes). Checks are made to ensure that prescriptions are only supplied to bona-fide NHS organisations.

**Non-NHS nurses**

48. Non-NHS nurses cannot issue a NHS prescription i.e. one written on a form GP10N or HBPN for dispensing in an NHS community pharmacy, unless the organisation they work for has an arrangement or 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 GP10N or HBPN prescription forms and obtain prescribers codes via PCIG in the usual way.

**Prescription forms for nurses and midwives in primary care**

49. Existing nurse prescribers will already have supplies of GP10N forms. These will be retained for existing ‘limited formulary’ nurse prescribers but will gradually be updated and replaced, so that by January 2003 limited formulary nurse prescribers will be using prescription forms pre-printed with the nurse’s name and NMC number. The forms will also be annotated DISTRICT NURSE/HEALTH VISITOR PRESCRIBER.

50. When a nurse qualifies to prescribe from the extended formulary the employer will be provided with a GP10N prescription pad which will also be pre-printed, and annotated EXTENDED FORMULARY NURSE PRESCRIBER.
51. GP10N prescription forms will also be pre-printed with the nurse prescriber code. Nurses directly employed by Primary Care Trusts working across more than one GP practice and using multiple prescriber codes will be issued with a prescription pad pre-printed with the prescriber code for the practice within which the nurse issues the majority of their prescriptions. For the additional practices they will be issued with a pad without a pre-printed prescriber code and will be required to manually enter the relevant prescriber code as necessary.

*Prescribing forms for hospital-based nurses and midwives*

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

- Ward order – to be used for inpatients 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 a GP10N prescription form *(NB internal hospital forms cannot be accepted for dispensing by community pharmacies)*.

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

HBPN prescription forms for hospital based nurses will not be pre-printed with nurse details. Each form should be stamped with the following items:

- EXTENDED FORMULARY PRESCRIBER
- NMC Number
- Contact telephone number
- Hospital/Department prescriber code.

*How to complete the prescription form*

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

54. Nurse and midwife prescribers who have taken the appropriate additional training, may prescribe items listed in the NPEF as published in Part 8C of the Scottish Drug Tariff and in the BNF. A dispensing contractor cannot legally dispense any other item prescribed by a nurse prescriber, and will not be reimbursed for any prescription containing such items.
55. 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.

56. 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 – NB it is a legal requirement to write the patient’s age on the prescription when prescribing Prescription Only Medicines for a child under 12 years of age
- CHI number, if known
- nurse prescribers should use the product description as listed in the NPF/NPEF
- for prescribing in primary care, 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)\(^5\) and special containers\(^7\) 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). 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. Current best practice requires quantity to be clear on the prescription form.

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\(^5\) 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.

\(^6\) 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.

\(^7\) 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.
in hospitals, prescriptions for in-patients should contain the name of the prescribed item, formulation, strength (if any), dosage and frequency. Where a defined length of treatment is required this should be stated. For outpatients and discharge prescriptions, the requirements are the same as those for primary/ community care, whilst recognising local policies for example on the length of treatment provided for outpatients and patients who were being discharged.

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, if for use or application by the patient or carer, 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

nurses should ensure the appropriate prescriber code is entered on the prescription form if this has not been pre-printed.

57. 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. Current best practice indicates that regular prescriptions should be issued for up to 28 days.

58. Items that require a doctor’s signature should not be entered on a nurse prescription even if the doctor countersigns them. A GP prescription must be used at all times when the GP’s signature is required.
ROLE OF THE PHARMACIST – ADVICE ON MEDICINES

59. 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.

60. To enable pharmacists to check whether a nurse prescription handed in for dispensing is bona fide, all NHSScotland 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.

61. Community pharmacists will expect to see primary care nurse prescriptions on a GP10N; hospital-based nurse prescriptions on an HBPN. Nurses must not use other types of prescription form.

62. 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, inappropriate, 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. See sample contained in Annex D.

SECURITY AND SAFE HANDLING OF PRESCRIPTION FORMS: GOOD PRACTICE

63. 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.

64. The nurse employer should record the serial numbers of prescriptions received and subsequently issued to individual prescribers, surgeries, clinics, etc. For this type of ‘stock control’ record, there is no need to record every number in each pad – just the first and last numbers of each pad. Note that the prescription serial number is the first 10 numbers (these run in sequence), the final digit is a check digit (and does not run in sequence).

65. Local policy should be established regarding monitoring the use of prescription forms to deter the creation of fraudulent prescriptions (see paras 105 and 106 re monitoring prescribing). For example, if practicable, a Practice or Prescribing Manager may undertake, from time to time, a reconciliation between the number of prescriptions written during a session with the number of forms used by individual prescribers. Or more detailed records, such as a log of each patient prescribed for and the serial number of the prescription issued to them may be required.
66. The nurse prescriber should also keep records 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.

67. Blank prescription forms should 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.

68. 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**

69. Practitioner Services Division (PSD) should be contacted about prescriptions ordered, but not delivered, at the address in para 47: ie Moira Gardner, Room D091, Trinity Park House, South Trinity Road, Edinburgh EH5 3SE.

70. Practice, community and PMS pilot nurse prescribers should report the loss or theft to the Primary Care Manager at the PCT/NHS Board 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 lost or stolen. The nurse should inform the GP (where appropriate) as soon as he/she is aware of missing scripts.

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

72. The Primary Care Manager should notify the Fraud Liaison Officer (FLO) at the PCT who should notify the local pharmacists and decide upon any necessary action to minimise the abuse of the forms. The FLO should notify the Practitioner Services Fraud Investigation Unit who will maintain a database of lost/stolen prescription forms.

73. Following the reported loss of a prescription form the PCT/NHS Board will normally tell the prescriber to write and sign all scripts in a particular colour (usually green) for a period of 2 months. The PCT/NHS Board will inform all pharmacies in their area and adjacent PCTs/NHS Boards 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.
74. In the event of a loss or suspected theft from any nurse, an Acute Trust-employed nurse should report this immediately to whoever issued the prescription forms (normally the hospital pharmacy) and the local 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 of theft of prescription forms – this may include writing and signing all scripts in a particular colour (usually green) for a period of 2 months.

75. 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 treated as 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

76. 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.

77. 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

78. 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 order items.

Informing patients

79. 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 to their care.
**Who to write prescriptions for**

80. 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. 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.

81. 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**

82. 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 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**

83. All nurses are required to keep contemporaneous records, which are unambiguous and legible. The NMC Guideline for Records and Record-Keeping outlines the requirements of nurses’ records. The record of the nurse 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 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. Where practicable, electronic records should be used, and prescriptions should be generated via these systems.

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8 Standard for records and record keeping, UKCC 1998.
84. It is recommended that the record clearly indicates the date, the name of the prescriber, the name of the item prescribed, formulation 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.

85. 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

86. 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 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.

LEGAL AND CLINICAL LIABILITY

Liability of employer

87. 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 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.
**Professional indemnity**

88. 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**

89. 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.

90. When submitting prescriptions to the PSD, dispensing practices should include them with their GP10 form count on their GP34 declaration and sort them as per existing instructions.

91. 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.

92. If any items dispensed are subsequently found not to be on Scottish Minister’s Nurse Prescribers’ list as set out in the Scottish Drug Tariff/Nurse Prescribers’ Extended Formulary, they will not be reimbursed.

**Nurses required to dispense in primary care**

93. As stated within the UKCC Guideline for the Administration of Medicines (2000), a nurse may be required to dispense ‘under exceptional circumstances’. Where this is likely to occur, the nurse’s employer should be aware of this practice. In addition, paragraphs 89-92 must be adhered to.

**VERIFICATION OF PRESCRIBING STATUS**

**The NMC Voice Bank**

94. Most queries from pharmacists will be resolved by telephoning the prescriber, the prescriber’s employer or the PCT (see paras 39-44). However, for general queries about qualification (e.g. in the case of receiving a private prescription), the pharmacist can telephone the NMC voice bank system. Pharmacists should follow the process using the necessary codes (see para 37). They will need to know the nurse prescriber’s NMC number and date of birth.
Role of the pharmacist on verification of prescribing status

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

96. From July 2002, nurse prescription forms for extended formulary prescribers will be printed with:

EXTENDED FORMULARY NURSE PRESCRIBER.

From January 2003 for DN/HV prescribers, they will be printed with:

DISTRICT NURSE/HEALTH VISITOR 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 printed with EXTENDED FORMULARY NURSE PRESCRIBER, pharmacists may dispense items from either the DN/HV or Extended Formulary.

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

98. Nurse and midwife prescriptions should be sorted as per existing instructions.

DISPENSING BY APPLIANCE CONTRACTORS

99. 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 submit as per existing instructions.

URGENT DISPENSING

100. 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 local pharmacies, NHS 24 or police stations.

DISPENSING OF ITEMS IN WALES AND NORTHERN IRELAND

101. Nurse and midwife prescriptions written by nurses in Scotland will only be dispensable by pharmacists in Wales 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

102. See also paragraph 52. An up-to-date list of all qualified nurse prescribers will need
to be kept in the pharmacy. It will be the responsibility of the nurse lead at the Trust
to keep this list up to date when circumstances change, e.g. a nurse prescriber
leaves his/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

Nurse and midwife prescribing monitoring information – primary care

103. The CSA reimburses costs to dispensing contractors and provides essential
monitoring information, both electronically and via paper reports, to authorised
users. Nurses can access information relating to their prescribing from their GP
practice who are sent nurse prescribing reports prepared by PCIG/ISD twice
annually. Individual nurse Scottish Prescribing Analysis (SPA) reports are only
available on request. Requests from nurse prescribers should be made on headed
notepaper to:

Trinity Park House, South Trinity Road, Edinburgh EH5 3SE.

Nurse prescribers will also be able to obtain SPA data from their local prescribing
advisor teams based at their LHCC or PCT.

Nurse and midwife prescribing monitoring in secondary care/other settings

104. 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

105. 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.

106. 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.

107. Assistance with identifying audit methodologies and interpreting findings should
be available through the employing organisations’ normal clinical governance
mechanisms.
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>DN</td>
<td>District Nurse</td>
</tr>
<tr>
<td>NES</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>GP10N</td>
<td>Prescription form for use by District Nurse/Health Visitor prescribers and Extended Formulary nurse/midwife prescribers’</td>
</tr>
<tr>
<td>HBPN</td>
<td>Prescription form for use by Hospital-Based Prescribing Nurses</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>MCA</td>
<td>Medicines Control Agency</td>
</tr>
<tr>
<td>NPF</td>
<td>Nurse Prescribers’ Formulary</td>
</tr>
<tr>
<td>NPEF</td>
<td>Nurse Prescribers’ Extended Formulary</td>
</tr>
<tr>
<td>CSA</td>
<td>Common Services Agency</td>
</tr>
<tr>
<td>PSD</td>
<td>Practitioner Services Division of the CSA</td>
</tr>
<tr>
<td>ISD</td>
<td>Information and Statistics Division of the CSA</td>
</tr>
<tr>
<td>PCIG</td>
<td>Primary Care Information Group of the CSA</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>SPA</td>
<td>Scottish Prescribing Analysis</td>
</tr>
<tr>
<td>LHCC</td>
<td>Local Health Care Co-operatives</td>
</tr>
<tr>
<td>SEHD</td>
<td>Scottish Executive Health Department</td>
</tr>
</tbody>
</table>
# ANNEX A

## NOTIFICATION OF NEWLY QUALIFIED NURSE PRESCRIBER/CHANGE OF CIRCUMSTANCES

*Use this form to advise details of all nurse or midwife prescribers. For nurses working across more than one practice please fill in one form per practice and indicate the principal prescribing practice.*

To: Primary Care Information Group, Trinity Park House, South Trinity Road, Edinburgh EH5 3SQ  
From: NHS Board/Trust  
Telephone

**Please tick applicable box**

- Change of name or NMC PIN  
  (Complete sections A and B)
- Change of qualification to prescribe  
  (Complete sections A and B)
- NHS employment begins or ends  
  (Complete sections A, B, C and D)
- Additional or change of practice  
  (Complete sections A, B, C and D)
- New nurse prescriber  
  (Complete sections A, B, C and D)

**Effective start date of change (must be completed)**

### 107.1

### 107.2 SECTION A: Nurse Details

<table>
<thead>
<tr>
<th>Details prior to change</th>
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<tbody>
<tr>
<td>1. Surname and Initials</td>
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</tr>
<tr>
<td>2. Job Title</td>
<td></td>
</tr>
<tr>
<td>3. NMC PIN</td>
<td></td>
</tr>
<tr>
<td>4. Unique Prescriber Code</td>
<td></td>
</tr>
<tr>
<td>5. Formulary (DN/HV or Extended)</td>
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</table>

### 107.3

### 107.4 SECTION B: Practice Details

<table>
<thead>
<tr>
<th>Details prior to change</th>
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<tbody>
<tr>
<td>1. Practice Code or Code of Senior GP</td>
<td></td>
</tr>
<tr>
<td>2. Practitioner/Senior GP name</td>
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</tr>
<tr>
<td>3. Practice Address</td>
<td></td>
</tr>
<tr>
<td>4. Principal prescribing practice* (Y/N)?</td>
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### 107.5

### 107.6 SECTION C: NHS Employer Details

<table>
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<td>1. Trust Name</td>
<td></td>
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<tr>
<td>2. Trust Address</td>
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### 107.7

### 107.8 SECTION D: Nurse Employment Details

<table>
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<tr>
<th>Details prior to change</th>
<th>Details of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Start date with Trust</td>
<td></td>
</tr>
<tr>
<td>2. End date with Trust</td>
<td></td>
</tr>
</tbody>
</table>

**Signature (NHS Board/PCT Officer):**  
**Name:**

<table>
<thead>
<tr>
<th>PCIG use only</th>
<th>Prescriber code:</th>
<th>Date issued:</th>
</tr>
</thead>
</table>

* For PCT nurses working across multiple practices only, the practice where the majority of their prescriptions are issued.*
ANNEX B

POLICY STATEMENT – RECORD KEEPING

All records created and maintained by health professionals should provide 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. Be written in terms which patients/clients will be able to understand.

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

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

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

12. Abbreviations are only acceptable from a locally agreed list.
POLICY STATEMENT – RECORD KEEPING AND NURSE PRESCRIBING

All nurses are required to keep contemporaneous records, which are unambiguous and legible.

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 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

NHS EDUCATION FOR SCOTLAND

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 Part 1, 3, 5, 8, 10, 11, 12, 13, 14 or 15 of the Professional Register maintained by the Nursing and Midwifery Council;

• have appropriate experience in the area of practice in which they will be prescribing;

• demonstrate an ability to study at academic SD Level 3;

• have support from the employing organisation;

• have a designated and qualified prescribing practitioner* who will provide the student with supervision, support and opportunities to develop competence in prescribing practice. (This includes shadowing opportunities.)

*This will be a medical practitioner at present.

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 3 and will enable the practitioner to:

- assess and consult with patients and carers;
- prescribe safely, appropriately and cost-effectively;
- apply the legislation relevant to the practice of nurse prescribing;
- use sources of information, advice and decision support appropriately in prescribing practice;
- critically evaluate the influences on prescribing practice;
- apply knowledge of medications in prescribing practice;
- demonstrate cognisance of the teamwork and communication networks involved in prescribing, supplying and administering medicines;
- practice 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, organisations, 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 and access to electronic patient records
- 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, organisations, 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 on Medicines (CSM)
- prescribing in the policy context
- manufacturers’ 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**

• NMC Code of Professional Conduct and Scope of Professional Practice
• accountability and responsibility for assessment, diagnosis, prescribing and over-the-counter medicines, etc.
• 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 reflecting 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.

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

The approved higher education institution must ensure that the designated prescribing 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 may include:

(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 qualified prescribing practitioner providing support, teaching and supervision of the student. Initially this will be a medical practitioner but in future it is envisaged that nurse prescribers may carry out this function.

LENGTH OF THE PROGRAMME

The programme should be 25 days or equivalent for the theory component, over a minimum period of 3 months. Alongside the theory component, students are expected to shadow their prescribing practitioner for the equivalent of one day per week of educationally led practice (12 days in total). The total length of the programme is therefore approximately 37 days or equivalent.

It is anticipated that the programme will attract approximately 20 academic credits at Level 3.
### ANNEX D

#### EXAMPLES OF PRESCRIPTION FORMS

![Prescription Form](image)

**FORM GP10N(2)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

**Age Under 12 yrs.**

- Yrs / Mths

**No. of Days Treatment**

<table>
<thead>
<tr>
<th>CH1 No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Pharmacy Stamp**

**Dispensing Endorsement**

**Pack size**

- Numbers only

**Signature of Nurse**

<table>
<thead>
<tr>
<th>X.XXXE</th>
<th>EXTENDED FORMULARY PRESCRIBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A SMITH</td>
<td>BSC 9F4999X</td>
</tr>
</tbody>
</table>

**Address:**

1 PAIN STREET
ANTONIA
X0929 90X

**Tel:** 9999 999 9999

**Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.**

**00380038**
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>12 yrs</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of Days</th>
<th>Treatment</th>
<th>CHI No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pack size:</th>
<th>Number only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pack size:</td>
<td>Number only</td>
</tr>
</tbody>
</table>

Signature of Nurse: A Smith  
Extended Formulary Prescriber:  
NMC 99999999  
Tel: 9999 999 9999

Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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</tbody>
</table>

Age if under 42 yrs.

Yes / No

No. of Days Treatment

Name name in block capitals

Signature of Name

Date

Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.

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