

# Supplementary Prescribing

A resource to help healthcare professionals to understand the framework and opportunities



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# Introduction

## Who is this resource for?

Supplementary prescribing is a brand new concept which will contribute to the delivery of high quality, flexible and patient-centred services. Given its intrinsic role in helping to achieve the aims of the National Health Service (NHS) modernisation agenda it is, therefore, vital that professionals, their managers and educators have a clear understanding of the objectives, scope and framework of supplementary prescribing, in order to maximise its potential.

## What does this resource aim to do?

During the spring of 2002 the National Prescribing Centre (NPC) produced a CD-ROM *Signposts for good prescribing*, which primarily aimed to support those involved in the initial preparation of nurse prescribers. It can also be used to help address some of the continuing professional development (CPD) needs of existing prescribers. Copies of the CD-ROM have been distributed to those Higher Education Institutions (HEIs) offering nurse prescribing training. They have been provided to their medical supporters via the HEIs. Further copies may be obtained from the NPC by contacting Karen Dooley (Administrator) on 0151 794 8210 or by email at [karen.dooley@npc.nhs.uk](mailto:karen.dooley@npc.nhs.uk).

This new web-based resource aims to:

- complement the information contained within the CD-ROM
- provide a concise overview of some of the elements of supplementary prescribing
- help users access definitive, up-to-date information from a number of credible sources

The information within this resource should be considered alongside the Department of Health (DH) guidance — *Supplementary prescribing by nurses and pharmacists within the NHS in England. A guide for implementation. 2003*.

## How can this resource be used?

The material in this resource can be used:

- to help understanding of the concept of supplementary prescribing
- as an aid to planning a teaching session
- as a learning aid for students
- to access information from other sources
- to obtain documents and journal articles
- to assist in addressing CPD needs

# Section 1

## The context of supplementary prescribing

The terms of reference of the Review of Prescribing, Supply and Administration of Medicines, chaired by Dr June Crown, required the review team to produce two reports:

- ❑ one concerned the supply and administration of medicines under group protocols (now referred to as Patient Group Directions [PGDs]) by nurses and other health care professionals. At the time this was thought to be an area of particular legal uncertainty
- ❑ the other report looked at the existing arrangements for prescribing, supply and administration of medicines (other than group protocols) and considered whether prescribing powers could be extended to other groups of health care professionals

### 1.1 Patient Group Directions

The first of these reports '*A Report on the Supply and Administration of Medicines under Group Protocols (1998)*', was supported by *Health Service Circular (HSC) 1998/051* and recommended that:

- ❑ safe and effective practice should continue
- ❑ the legal position of group protocols should be clarified
- ❑ all group protocols for the supply and administration of medicines should comply with set criteria

*HSC 2000/026. Patient Group Directions (England Only)* set out the legal requirements and guidance for the use of PGDs and defines them as:

*'... written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.'*

A centrally maintained archive of PGDs can be accessed at [www.groupprotocols.org.uk](http://www.groupprotocols.org.uk)

A flow chart to help practitioners to decide when the use of PGDs is appropriate '*To PGD Or Not To PGD*', has been produced by the Pharmacy Community Care Liaison Group.

## 1.2 The Review of Prescribing, Supply and Administration of Medicines

Following the successful piloting of prescribing by district nurses and health visitors, the report of the *Review of Prescribing, Supply and Administration of Medicines (1999)* proposed:

- ❑ the introduction of a new framework of prescribing, supply and administration of medicines whereby the majority of patients would continue to receive medicines on an individual patient-specific basis
- ❑ the prescribing authority of doctors, dentists, and district nurses and health visitors would continue
- ❑ prescribing authority would be extended to include new groups of health care professionals

Recommendations of the report included:

- ❑ the extension of prescribing to include other groups of health care professionals
- ❑ the introduction of a distinction between two categories of prescribers:
  - **independent prescribers** who would be responsible for the initial assessment of the patient and drawing up a treatment plan. The independent prescriber also has the authority to prescribe the medicines required as part of the plan
  - **supplementary prescribers** (then referred to as 'dependent' prescribers) who would be authorised to prescribe for patients whose condition had been diagnosed or assessed by an independent prescriber, within the parameters of an agreed treatment plan

Following publication of this report, Health Ministers focused on:

- ❑ initially extending independent nurse prescribing
- ❑ introducing supplementary prescribing by nurses and pharmacists. As these are the most numerous non-medical professions, it is expected this development will maximise benefits to patient care

## 1.3 Extension of independent nurse prescribing

Following *consultation on extending independent nurse prescribing*, on the 4<sup>th</sup> May 2001 the Government announced in *Press release: reference 2001/0223. Patients to get quicker access to medicines* that:

- ❑ prescribing authority would be extended to enable more nurses to prescribe treatments for a broader range of medical conditions. This included the prescription of all General Sales List and Pharmacy items prescribable by doctors, plus a list of *Prescription Only Medicines*.

### 1.3.1 Training

The *outline curriculum for the preparation of nurses to prescribe from the Nurse Prescribers Extended Formulary (NPEF)* [www.nmc-uk.org](http://www.nmc-uk.org) was developed by a multidisciplinary team of experts, led by the English National Board for Nurses, Midwives and Health Visitors during the summer of 2001. Training has been available since early 2002.

### 1.3.2 Competency

The competencies that district nurse, health visitor and extended nurse prescribers need to ensure that they continue to prescribe safely and effectively were identified by the NPC. This framework is presented within the first edition of *Maintaining competency in prescribing. An outline framework to help nurse prescribers. First Edition 2001*, published in November 2001.

This document was circulated to existing nurse prescribers during December 2001. Since then nurse prescribers have received a copy during the initial training course, via the HEIs. Further copies can be obtained from the [NPC website](#).

## 1.4 Supplementary prescribing

The *Press release: reference 2001/0223. Patients to get quicker access to medicines* also confirmed the Government's intention to allow the introduction of supplementary prescribing.

Proposals to implement supplementary prescribing by nurses and pharmacists were announced by Health Minister Lord Hunt on 14<sup>th</sup> April 2002 — *Press release: reference 2002/0189. Groundbreaking new consultation aims to extend prescribing powers for pharmacists and nurses.*

At the same time the DH and the Medicines and Healthcare products Regulation Agency (MHRA), formerly known as Medicines Control Agency (MCA) began a formal, three month consultation on proposals to implement supplementary prescribing for nurses and pharmacists, detailed in ***Proposals for Supplementary Prescribing by Nurses and Pharmacists and Proposed Amendments to the Prescription Only Medicines Order (MLX 284)***. This is available from the [MHRA web site](#) by selecting 'What's new ' from the menu.

Drawing on the results of this consultation, recommendations were made to Ministers by the Committee on Safety of Medicines (CSM) and the Medicines Commission. On 21<sup>st</sup> November 2002, a further announcement by Lord Hunt confirmed the decision to introduce supplementary prescribing by nurses and pharmacists. This is detailed in *Press release: reference 2002/0488. Pharmacists to prescribe for the first time. Nurses will prescribe for chronic illness.*

## **1.5 Forms of nurse and pharmacist prescribing and supply of medicines**

A comprehensive summary of the parameters of the various forms of prescribing and supplying medicines can be found at [www.doh.gov.uk/nurseprescribing/formsofprescribingjan03.pdf](http://www.doh.gov.uk/nurseprescribing/formsofprescribingjan03.pdf)

## Section 2

### The wider policy context

The introduction of prescribing by non-medical health care professionals should not be seen in isolation, but as an integral part of the larger agenda to modernise the NHS. The Government clearly views the extension of prescribing authority to other health care professionals as fundamental to this process. This has been confirmed within several DH documents during recent years.

#### 2.1 Making a difference

During 1999, the DH published a strategy for nurses, health visitors and midwives — *Making a difference. Strengthening the nursing, midwifery and health visitor contribution to health and healthcare*. This document maps out how these professions can improve services and patient care, which includes the continual development of knowledge, skills and role extension. Building on the success of implementing prescribing by district nurses and health visitors, and acknowledging the potential of the nursing profession in terms of improving services and enhancing patient care, this document re-affirmed the government's intention to:

*'... extend the role of nurses, midwives and health visitors to make better use of their knowledge and skills — including making it easier for them to prescribe'*

This commitment was re-emphasised by the Chief Nursing Officer for England in 2000, in defining the *Ten Key Roles for Nursing*. Number six states that nurses will:

*'...prescribe medicines and treatments'*

#### 2.2 The NHS Plan

*The NHS Plan: A plan for investment, A plan for reform*, published in 2000, aims to give the public a health service which:

- is designed around the needs of the patient
- provides fast and convenient care
- offers more choice and promotes 'one-stop' care
- improves the quality of care
- reduces access and waiting times

The ways which this will be achieved include:

- empowering front line staff and patients. The programme for bringing about this change is detailed within *Shifting the balance of power*
- harnessing and expanding the skills of all health care professionals
- breaking down traditional demarcations between clinical roles
- increasing flexibility of team working

Extending prescribing authority to other health care professionals will:

- play a key role in achieving all of these aims
- enable non-medical prescribers to contribute to meeting the needs of local health economies following the introduction of the new GP/consultant contract and the reduction of junior doctor's hours
- contribute to the wider Public Health agenda by enabling teams of health care professionals to deliver more flexible services and, sometimes, complete episodes of care, to hard to reach and vulnerable groups

A framework for planning and delivering nursing services in primary care which are responsive to the needs of the patient and the community is set out in *Liberating the Talents* published by the DH in 2002.

### **2.3 Pharmacy in the future — Implementing the NHS Plan (2000)**

This document sets out the vital role of pharmacy in delivering the NHS Plan, the vision for pharmacy and an outline programme for the development of pharmacy services in the UK. The following three key challenges are identified:

- meeting the changing needs of patients
- responding to the changing environment
- enhancing public confidence in the profession

In order to achieve the aims of this programme, pharmacists will have to:

- work more flexibly alongside other professionals and support staff
- spend more time focusing on individual patients' clinical needs and in particular helping them to get the most out of their medicines
- work in a system which:
  - promotes lifelong learning and continuing professional development
  - offers patient certainty that services are quality assured

Future pharmacy services will:

- be designed around the needs of patients, not organisations
- be integrated with other services
- make best use of all staff and their skills
- take advantage of modern technologies

In redesigning services around patients and developing the right structures, it is envisaged that prescribing powers will make better use of pharmacist's clinical skills. This will open up new opportunities for suitably qualified pharmacists to integrate the prescribing role into their existing responsibilities. This role will begin with supplementary prescribing and, subject to developments, may include independent prescribing in the future.

## Section 3

# The concept of supplementary prescribing

### 3.1 Legal framework

The law which governs prescribing is found in the:

- ❑ *Medicines Act 1968 (Primary legislation)*, which sets out the groups of professionals who can prescribe and the manner in which Prescription Only Medicines can be supplied and administered
- ❑ *Medicinal Products: Prescription by Nurses etc., Act 1992*. This amends the Medicines Act 1968 to include registered nurses, midwives and health visitors 'who are of such a description and comply with such conditions as may be specified in the order'
- ❑ *Medicines (Products other than veterinary drugs) (Prescription Only) Order 1983 SI 1212*. This contains many definitions relating to prescribing of Prescription Only Medicines and it must be read in conjunction with the Medicines Act 1968 and the Medicinal Products: Prescription by Nurses etc., Act 1992
- ❑ *Health and Social Care Act 2001*. Section 63 allows Ministers, by order, to designate new categories of prescriber, and to set conditions for their prescribing

### 3.2 Definition

Supplementary prescribing is defined by the DH as:

*'... a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement.'*

### 3.3 Key features

The key principles that should underpin supplementary prescribing emphasise:

- ❑ the importance of communication between the prescribing partners
- ❑ the need for access to shared patient records
- ❑ that the patient is treated as a partner in their care and is involved at all stages in decision-making, including whether part of their care is delivered via supplementary prescribing

## 3.4 Preparation of supplementary prescribers

### 3.4.1 For nurses

Preparation for nurse supplementary prescribers began in early 2003. The curriculum is based on that for extended independent nurse prescribers with an *additional taught element relating to the nature, context and scope of supplementary prescribing*. This means that the taught element should be at least 26 days.

*The Nursing and Midwifery Council (NMC) Circular 25/2002* sets out new standards for combined extended nurse prescribing and supplementary prescribing preparation. This means that nurses completing this course will hold both qualifications. Courses currently delivering extended nurse prescribing training can be modified to incorporate the additional supplementary prescribing elements provided the modifications have been approved internally and confirmed with the NMC.

Nurses who are already qualified extended independent nurse prescribers will be able to 'top up', provided there is a local need for them to do so.

### 3.4.2 For pharmacists

Courses to train pharmacist supplementary prescribers are expected to be in place by mid-2003. Using the outline curriculum for extended nurse prescribing preparation as a basis, *an outline curriculum for pharmacist supplementary prescribing training* has been developed by a multidisciplinary team, led by the Royal Pharmaceutical Society of Great Britain (RPSGB).

## 3.5 Competencies for supplementary prescribing

Building on earlier work which identified the competencies needed by district nurse, health visitor and extended nurse prescribers, the NPC has developed competency frameworks for both nurse and pharmacist supplementary prescribers.

This new framework will be available to nurses from the *NPC website* and should be used as an addendum to the document *Maintaining competency in prescribing. An outline framework to help nurse prescribers. First Edition 2001*.

For pharmacists, the competency framework is incorporated into a new NPC publication — *Maintaining competency in prescribing. An outline framework to help pharmacist supplementary prescribers. First edition 2003*. This document will be provided to pharmacist supplementary prescribers during their initial training programmes.

## Section 4

# The scope of supplementary prescribing

### 4.1 Range of conditions to be treated by supplementary prescribers

There are no legal restrictions on the clinical conditions that a supplementary prescriber may treat. Because supplementary prescribing requires a prescribing partnership and a Clinical Management Plan (CMP) for the patient before it can begin, it is likely to be most useful when dealing with long-term medical conditions (such as asthma, diabetes or coronary heart disease) or with long-term health needs, such as anticoagulation. However, it will be for the independent prescriber to decide with the supplementary prescriber, in drawing up the CMP, when supplementary prescribing will be appropriate.

### 4.2 Medicines to be prescribed by supplementary prescribers

Unlike district nurse, health visitor and extended nurse prescribing, there is no specific formulary or list of medicines for supplementary prescribing. Provided medicines are prescribable by a doctor or dentist (an independent prescriber) at NHS expense, and that they are referred to in the patient's CMP, supplementary prescribers are able to prescribe:

- ❑ all General Sales List medicines, Pharmacy medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances
- ❑ all Prescription Only Medicines with the current exception of controlled drugs
- ❑ medicines for use outside of their licensed indications (i.e. 'off label' prescribing), 'black triangle' drugs, and drugs marked 'less suitable for prescribing' in the British National Formulary (BNF)
- ❑ **NB** Unlicensed drugs may not be prescribed unless they are part of a clinical trial which has a clinical trial certificate or exemption

In addition, the supplementary prescriber should not prescribe any medicine that they do not feel competent to prescribe.

## Section 5

# The Clinical Management Plan

### 5.1 What is a CMP?

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A CMP:

- is a lawful requirement. Supplementary prescribing can not happen without a CMP
- is a patient-specific document which relates to an individual patient. Once it has been drawn up in conjunction with and agreed by the independent and supplementary prescribers, and the arrangement endorsed by the patient, the CMP enables the supplementary prescriber to manage the treatment of individual patients (including prescribing), within the identified parameters
- should be fairly simple and quick to complete
- should not duplicate a lot of information which is in the shared medical record

### 5.2 What information should be included in the CMP?

The CMP should contain enough detail to ensure patient safety and must:

- specify the range and circumstances within which the supplementary prescriber can vary the dosage, frequency and formulation of the medicines identified (medicines may be listed by class, formulation or specific product, at the independent prescriber's discretion, or be identified by reference to reputable guidelines or protocols for a specific condition)
- specify when to refer from supplementary prescriber to independent prescriber
- contain relevant warnings about known sensitivities of the patient to particular medicines, and include arrangements for notification of adverse drug reactions
- contain the date of commencement of the arrangement and date for review (not normally longer than one year, and much shorter than this if the patient is being prescribed antibiotics)

### 5.3 Template CMPs

Two template CMPs, which can be developed to meet individual needs are available from the [DH website](#).

## Section 6

# The prescribing partnership

### 6.1 Who are the partners?

Supplementary prescribing hinges on the formation of a voluntary prescribing partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber.

It is envisaged that the prescribing partners will normally work in fairly close proximity, for example, a nurse practitioner working with a GP, or a pharmacist working in a GP practice. In situations where the health care professionals work more remotely, such as a specialist nurse covering a wide geographical area, a prescribing partnership may only be possible when the prescribing partners have access to shared electronic patient records.

In addition, good prescribing practice requires that the patient is also considered an equal partner in order to ensure informed consent and concordance (*The Task Force on Medicines Partnership, 2002*).

### 6.2 Teams of prescribers

In certain circumstances, and in order to ensure continuity of care, access and equity it will also be possible to have teams of independent and supplementary prescribers involved in managing the treatment of individual patients. When this is the case a 'lead' independent prescriber should be nominated.

### 6.3 Responsibilities of the prescribing partners

Because supplementary prescribing involves a team approach, clear identification and common understanding of individual roles and responsibilities, along with frequent communication between the prescribing partners is essential for safe, effective prescribing.

The prescribing partners are responsible for ensuring that the *criteria for lawful supplementary prescribing* is upheld. This involves ensuring that:

- ❑ the independent prescriber is a doctor or dentist
- ❑ the supplementary prescriber is a registered nurse, registered midwife or registered pharmacist
- ❑ there is a written CMP relating to a named patient and to that patient's specific conditions. Agreement to the plan must be recorded by both the independent and supplementary prescriber before supplementary prescribing begins
- ❑ the independent and supplementary prescriber share, have access to, consult and use the same patient record

As with every area of practice, individuals are professionally accountable for their own actions, including their prescribing decisions. Employers remain vicariously liable for the actions and decisions of their staff.

# Section 7

## Maintaining the integrity of the prescribing partnership

### 7.1 Managing potential conflict

If the potential of supplementary prescribing is to be realised, several changes will need to occur. For example:

- accepted roles and responsibilities will have to be challenged
- new roles will have to be developed
- new working relationships will have to be created between all concerned
- all prescribers will have to view each other as equal partners

Although changes in roles have the potential to create conflict of ideas, it can also enable individuals to challenge and enhance personal development (Rashid and Bentley 2001). *Journal of Community Nursing*. [www.jcn.co.uk](http://www.jcn.co.uk)

Indicators for potential conflict may include:

- lack of trust or credibility between individuals
- organisational and service issues relating to the provision of training and development opportunities and/or infrastructures
- perceived inequity of power, accountability and responsibility within the prescribing partnership
- responsibility for instigation, development, maintenance and review of the CMP

Potential conflict can often be avoided through:

- effective communication
- equitable working relationships
- clarifying working practices
- facilitating clinical supervision and continuing professional development opportunities

## 7.2 Managing perceived poor prescribing practice

A difficult situation may arise when perceived poor prescribing practice is identified within the team.

Individuals who identify poor prescribing practice will require support both from within the prescribing team, and from the managerial structure within the organisation.

Poor practice can be minimised by:

- ❑ adhering to the principles of good prescribing, as specified in the World Health Organisation's document — *Guide to good prescribing. A practical manual 1996* [www.who.int](http://www.who.int).
- ❑ following established clinical guidelines such as those produced by the *National Institute for Clinical Excellence (NICE)* and *PRODIGY*

# Section 8

## Risk management

### 8.1 The culture

The need to manage risk is well established within the culture of the NHS and the introduction of clinical governance provides a structured framework to enable this process.

In June 2000, a team of experts, led by the Chief Medical Officer, reported on:

- ❑ the scale and nature of serious failures in NHS care
- ❑ how the NHS could learn from its mistakes in care delivery
- ❑ measures which could minimise future risk

This report — *An organisation with a memory: report of an expert group on learning from adverse events in the NHS* found that, although serious failures appear uncommon in relation to the volume of care delivered by the NHS, when they do occur they:

- ❑ have devastating consequences for individual patients and their families
- ❑ cause distress to the (usually very committed) health care staff involved
- ❑ undermine public confidence in the services the NHS provides

The report also confirmed that:

- ❑ reporting and information systems provide a patchy and incomplete picture of the scale and nature of the problem, yet nearly 10,000 people are reported to have experienced serious adverse reactions to drugs in one year.

Recommendations as to how this problem could be minimised include;

- ❑ adopting a 'safety culture' (as opposed to a 'blame culture') in which reporting and balanced analysis are encouraged to have a positive and measurable effect on performance
- ❑ implementing unified mechanisms for reporting and analysis when things go wrong
- ❑ facilitating a wider appreciation of the value of the system approach to preventing, analysing and learning from mistakes

## 8.2 Reporting adverse incidents

An estimated 850,000 incidents and errors occur every year. [The National Patient Safety Agency \(NPSA\)](#), which was created in July 2001 aims to improve patient safety by:

- collecting and analysing information on adverse incidents
- considering safety-related information from other reporting systems
- learning lessons and feeding this information back
- ensuring that where risks exist, solutions are found, national goals are specified and mechanisms are put in place to track progress

The NPSA also aims to promote an open and fair culture which encourages staff to report adverse events without fear of personal recrimination.

## 8.3 Reporting adverse drug reactions: the 'Yellow Card' scheme

The 'Yellow Card' scheme for spontaneous reporting of suspected adverse drug reactions (ADRs) was introduced in 1964 after the thalidomide tragedy highlighted the urgent need for routine post-marketing surveillance of medicines.

Since then more than 400,000 reports of suspected ADRs have been submitted to the [CSM / MHRA](#).

These reports are made on a voluntary basis by doctors, dentists, pharmacists, coroners and, since Autumn 2002, by nurses midwives and health visitors. Pharmaceutical companies have a statutory obligation to report suspected ADRs.

The new electronic Yellow Card was launched on 31st October 2002 and all health professionals are encouraged to use it.

Guidance notes for reporting ADRs, and to provide an understanding of why and how suspected ADRs should be reported, are available from the MCA.

## 8.4 Writing a prescription

One potential area of risk relates to the accuracy and clarity of writing prescriptions. The [Prescription Pricing Authority \(PPA\)](#) website contains a step-by-step educational resource on the completion of NHS FP10 prescriptions, which are used in primary care.

## 8.5 Security and safe handling of prescription pads

The security of NHS prescription forms is the responsibility of both the prescriber and the employing organisation. [Extending independent nurse prescribing within the NHS in England: a guide for implementation](#) published by the DH in 2002, details how this issue should be approached.

## 8.6 Maintaining competency in prescribing

Risk may also be lessened by ensuring that prescribers are confident and competent.

As with every other area of practice, the prescriber should identify and meet their individual continuing professional development needs in order to exercise their professional accountability and duty of care fully.

The employing organisation also has a responsibility to ensure that their employers are fit for purpose.

Outline frameworks of the competencies required by nurse and pharmacist prescribers have been developed by the NPC and are available from its website. These frameworks can be used by:

- individual prescribers to help them reflect on their prescribing practice, monitor their level of competence and identify learning needs
- organisations to help identify common learning needs and commission appropriate CPD opportunities

## 8.7 Communication and record keeping

Good channels of communication and robust record keeping are fundamental to enabling supplementary prescribing.

As well as ensuring that each [CMP](#) contains all of the required information, prescribers must also adhere to guidelines and standards laid down by their governing professional bodies (that is, the [Nursing and Midwifery Council](#) for nurses and the [RPSGB](#) for pharmacists).

## Section 9

# Budget setting and monitoring prescribing

There are a number of key links to help prescribers understand the budgeting process. These include:

- ❑ The *Primary Care section* on the DH website
- ❑ The *Prescribing section* of the DH website
- ❑ The *Finance Manual*, which provides web based access to a range of financial guidance
- ❑ The *Prescribing Support Unit (PSU)*
- ❑ The *Prescription Pricing Authority (PPA)*

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