Hull Teaching Primary Care Trust

POLICY FOR PRESCRIBING BY NON MEDICAL STAFF

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1 INTRODUCTION

1.1 The aim of this policy is to provide guidance for non-medical prescribers and to clarify the administrative and procedural steps required to enable non-medical prescribing within Hull Teaching Primary Care Trust. It is inline with the non medical prescribing policy for the East Riding of Yorkshire Primary Care Trust.

1.2 This policy applies to all staff registered as non-medical prescribers (as defined in section 2 of this policy) who are directly employed by Hull Teaching Primary Care Trust as well as those employed by independent contractors undertaking the primary care trust's business.

1.3 This policy does not cover the supply or use of drugs under Patient Group Directions within the organisation.

1.4 This policy should be read in conjunction with the latest version of:-

1.5 Extending Independent Nurse Prescribing within the NHS in England (DoH 2005)

1.6 Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and Radiographers within the NHS in England (DH May 2005)

1.7 Improving Patient's access to medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England (DH April 2006)

1.8 Nursing and Midwifery Council (NMC): NMC standards of proficiency for nurse and midwife prescribers 2006.

2. ELIGIBILTY TO PRESCRIBE

2.1 To be legally eligible to prescribe the non-medical prescriber must

- Have successfully completed a validated Prescribing Training Programme
- Have their name annotated on the appropriate professional register
- Be in a prescribing post
- Have access to a prescribing budget

2.2 Please refer to the pathway from completion of prescribing programme to prescribing (Appendix 2)

3. TYPES OF NON-MEDICAL PRESCRIBING

3.1 Community Practitioner Nurse Prescriber (formerly Nurse Prescriber)

3.1.1 A qualified community practitioner nurse prescriber may prescribe if they have successfully completed approved nurse prescribing training and are registered with the Nursing and Midwifery Council with an annotation indicating they are a qualified prescriber.

3.1.2 Community practitioner nurse prescribers may only prescribe from Nurse Prescribers' Formulary for community practitioners as listed in the Nurse Prescribers Formulary/ British National Formulary (Drug Tariff/NPF/BNF).

3.2 Nurse Independent Prescribers

3.2.1 A nurse independent prescriber is a registered nurse who has successfully completed an appropriate validated prescribing training programme and has had that training registered with the Nursing and Midwifery Council. That professional register will include their names with an annotation indicating nurse independent prescribing qualification.

3.2.2 Nurse independent prescribers may prescribe any licensed medicine (i.e. products with a UK marketing authorisation) for any medical condition. Nurse independent prescribers are able to prescribe independently from the list of controlled drugs. This list is available in the Drug Tariff (part XVIIB) and in the September 2006 edition (and beyond) of the BNF.

3.3 Pharmacist Independent Prescribers

3.3.1 Pharmacist Independent Prescribers can prescribe any licensed medicine for any medical condition, with the exception of all controlled drugs until such time as there are changes to the Home Office's Misuse of Drugs regulations.

3.3.2 Nurse and pharmacist independent prescribers may prescribe medicines independently for uses outside their licensed indications/UK marketing authorization (so called 'off license' or 'off label'). They must however, accept professional, clinical and legal responsibility for that prescribing, and should only prescribe 'off label' where it is accepted clinical practice.

3.3.3 Nurse and pharmacist independent prescribers are not permitted to prescribe unlicensed medicines.

3.3.4 Nurse and pharmacist independent prescribers may also prescribe any appliances/dressings that are listed in Part IX of the Drug Tariff.

3.4 Supplementary Prescribing

3.4.1 Supplementary prescribers have successfully completed an appropriate validated prescribing training programme and their names are registered with the relevant professional body with an annotation indicating supplementary prescribing qualification.

3.4.2 Supplementary Prescribing is defined as "a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan with the patient's agreement" Department of Health (2003) thus enhancing partnership working in a more flexible approach to care delivery. (Appendix 1 – Template for Clinical Management Plans and Supplementary Prescribing).

3.4.3 Currently, there is no specific formulary or list of medications for supplementary prescribing. Provided medicines are prescribable by a doctor or dentist at NHS expense and are referred to in the patient's clinical management plan, supplementary prescribers are able to prescribe all General Sales List (GSL), Pharmacy medicines (P), appliances and devices, foods and other borderline

substances approved by the Advisory Committee on Borderline Substances, and all Prescription Only Medicines, including controlled drugs.

4. PRESCRIBING OF CONTROLLED DRUGS

4.1 Nurse Independent Prescribers are able to prescribe independently the list of Controlled Drugs, as indicated in the drug tariff, solely for the medical conditions indicated. This list is available in the Drug Tariff (part XVIIB) and in the September 2006 edition (and beyond) of the BNF.

4.2 To remain within the individual's scope of practice, only nurses with the appropriate level of expertise, knowledge and skills to assess, diagnose and initiate treatment in the areas identified in the Drug Tariff are eligible to be involved in this prescribing activity.

4.3 In the case of a Nurse Independent Prescriber, prescribing Controlled Drugs and administering, a second qualified person **must** check the quantity / volume and strength of the drug prior to administration.

4.4 In the case of supplementary prescribers, controlled drugs may be prescribed as defined within the clinical management plan.

5. SAFE DISPOSAL OF MEDICATION

5.1 General Disposal

5.1.1 All practitioners should advise patients, relatives and carers to return all unused drugs to a community pharmacy for safe disposal. It does not have to be the dispensary where they were dispensed.

5.2 Controlled Drugs

5.2.1 A controlled drug ceases to be classified as such once it is denatured, dissipated, is not re-usable or has been rendered irretrievable. All drugs, once disposed of, should be unrecognisable as such. Syringes containing residual unused controlled drugs should therefore be emptied before being discarded and the residual controlled drug disposed of into a sharps bin onto absorbable material (e.g. cat litter, or wall paper paste). This should be recorded in the patient's records and witnessed where possible by a relative, carer or colleague. (Appendix 8).

5.2.2 Controlled drugs can be returned to a community pharmacy for safe disposal as long as they are patient returns. (Appendix 8).

6. OBTAINING PRESCRIPTION FORMS

6.1 The employer will ensure that the Prescription Pricing Authority (PPA) is informed and updated about the details of all non-medical prescribers registered with the organisation.

6.2 PPA forms Annex A2 or A3 (Notification of Newly Qualified Nurse/Supplementary Prescriber/Change In Circumstances) will be used for this purpose (Appendix 3).

6.3 The PPA registers non-medical prescribers and passes a data file to the NHS contracted printer and supplier (Astron). Astron will print personalized and PCT coded prescription forms as requested. Orders for prescription pads can be placed approximately 2 weeks after details are sent to the PPA.

6.4 Non-medical prescribers will request their own prescription forms through systems established within the organisation. (Prescription Pad Procedure – Appendix 2).

6.5 An appropriate audit trail/records will be implemented within the organisation for ordering of prescription forms. PPA deliver to one central point in the organisation. It is the responsibility of the organisation to distribute prescription forms in accordance with these arrangements.

7. COMPLETING PRESCRIPTION FORMS

7.1 All details on a prescription form must be written clearly and legibly in black ink. The details required are:

- Patient's forename, surname and address (if community based)
- NHS Number if available
- Patient's date of birth (and age if under 12 years)
- Name and strength of prescribed item (weight if appropriate)
- Dosage, frequency and directions for use
- Quantity to be dispensed
- Patient's practice code
- Hospital Number (if an inpatient)
- Contact telephone number of prescriber

7.2 The prescription form FP10P is printed with the nurse prescriber's name, NMC/ HPC/RPSGB number and annotated with the prescribing qualification: i.e. community practitioner nurse prescriber; nurse/pharmacist independent prescriber or supplementary prescriber.

7.3 The prescriber must initial any alteration to the detail on a prescription.

7.4 Where there is more than one item on a prescription form a line should be inserted between each item. Any unused space must be blocked out with a diagonal line.

7.5 Under no circumstances should blank prescription forms be pre-signed before use.

7.6 Prescribers must ensure the correct GP practice identification code is used on each prescription when community based.

7.7 Nurse prescribers for hospital in-patients or outpatients may use three methods to prescribe:

- Hospital in-patient prescription form or sheet – to be used for in-patients and discharge supplies only. A prescription charge is not levied for 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

- FP10 type prescription forms, where the medicine will be prescribed by a hospital prescriber and dispensed by a community pharmacist.

7.8 Further guidance on prescription writing can be found in the NPF/BNF

8. ROLE OF THE PHARMACIST IN DISPENSING INDEPENDENT PRESCRIBERS PRESCRIPTIONS

8.1 In keeping with the principles of safety, clinical and corporate governance there should be a separation of prescribing and dispensing roles.

8.2 This is reflected in The Royal Pharmaceutical Society of Great Britain's standard on prescribing within the Code of Ethics and Standards which states that pharmacists should ensure that there is separation of prescribing and dispensing wherever possible.

8.3 In exceptional circumstances, where the independent prescriber is both prescribing and dispensing a patient's medication, a second suitably competent person should be involved in the checking process.

8.4 The audit arrangements must allow checking for clinical appropriateness.

8.5 In such exceptional circumstances, prescribing and dispensing can be carried out by the same individual provided that:

- Clear accountability arrangements are in place to ensure patient safety and probity, and
- There are audit and clinical governance arrangements in place which can track prescribing and dispensing by nurse and pharmacist independent prescribers. Where the two roles do co-exist, another person must carry out a final accuracy check. Where possible a check for clinical appropriateness should also be carried out.

9. PRESCRIPTION PAD SECURITY

9.1 The organisation will maintain a list of signatories of all non-medical prescribers who prescribe for patients who are registered with the organisation. All non-medical prescribers should be prepared to provide a specimen signature to community pharmacists if required.

9.2 Prescription pads are the property of the employer. It is the responsibility of the non-medical prescriber to ensure security of the prescription pad at all times**.**

9.3 Prescribers should keep a record of the serial numbers of the prescriptions in the pad issued to them. The prescriber and employing organisation should record the first and last serial number of the prescription pad. (Prescription Pad Audit – Appendix 4).

9.4 It is also good practice for the non-medical prescriber to record the number of the first and remaining forms of an in use pad at the end of the working day.

9.5 The prescription pad should only be produced when needed and never left unattended.

9.6 The prescription pad must not be left on the desk but placed in a locked drawer, filing cabinet or cupboard.

9.7 Under no circumstances should blank prescription forms be signed before use.

9.8 When traveling between patients the prescription pad must not be visible.

10. LOSS OF PRESCRIPTION FORMS

10.1 In the event of prescriptions ordered but not received, the Dispatch Supervisor, will contact Astron. Prescribers should report the loss or theft of prescription forms to their manager and to the PCT alert co-ordinator. The following information will be required:

- Prescribers name
- Professional registration number (e.g. NMC/HPC/RPSGB number)
- First and last serial numbers of prescription forms
- Details of loss/theft

10.2 The prescriber must complete an adverse incident form.

10.3 Where the loss/theft occurs outside of normal office hours, the non-medical prescriber must immediately contact the on call manager, report the loss/theft to the police and complete an incident form. The line manager and the Dispatch Supervisor should then be informed at the earliest opportunity. Managers must ensure the loss/theft has been reported and that an incident form is completed by the non-medical prescriber.

10.4 Following the loss/theft of prescription forms the prescriber will be requested to write and sign prescription forms in particular colour of ink for a period of one month. Please see flowchart relating to the procedure for the loss or theft of prescriptions (Appendix 5).

10.5 The PCT alert co-ordinator will ensure pharmacies and adjacent PCTs are informed of the name and professional identification number of the prescriber concerned; the number of prescription forms list/stolen and the period for which the prescriber will write in the specific colour. This information will be sent out the same day by first class post.

10.6 On termination of employment prescribers should ensure that their prescription forms are returned to the nominated lead who will ensure that serial numbers are recorded before pads are securely destroyed (Prescription Pad Audit – Appendix 4).

11. RECORD KEEPING

11.1 All non-medical prescribers are required to keep contemporaneous records, which are unambiguous and legible.

11.2 A record of a prescription must be entered into the patient's hand held / GP records / patient notes (as appropriate) at time of writing. A record of the prescription and

consultation with the patient should be entered into the GP patient record / hospital notes (as appropriate) as soon as possible. The record should indicate non-medical prescribing and include the name of the prescriber. (Appendix 7)

11.3 The time between writing a prescription and recording in the GP / Hospital records must not exceed 48 hours from writing the prescription.

11.4 The record should include:

- Date
- Name of prescriber
- Name of item prescribed
- Dose and frequency
- Quantity and treatment duration
- Advice given on over the counter items

11.5 In some circumstances, in the clinical judgment of the prescriber, it may be necessary to advise the GP / Consultant immediately of a prescription. This action should be recorded in the patient records.

12. ADVERSE REACTION REPORTING

12.1 If a patient suffers a suspected adverse reaction to a prescribed over the counter or herbal medicine it must be reported to the GP.

12.2 Non-medical prescribers should report adverse drug reactions to the Medicines and Healthcare Products Regulatory Agency (MHRA) / Committee on Safety of Medicines (CSM) by use of the Yellow Card Adverse Drug Reactions Reporting Scheme, if it was not a predicted reaction or a black triangle drug, if it occurred within a child or if herbal remedies had been taken.

12.3 Yellow cards are found at the back of the BNF or can be completed on line (www.mhra.gov.uk). All suspected adverse reactions for black triangle drugs should be reported and only serious adverse reactions for established drugs.

12.4 Details of any adverse reaction and any action taken by the non-medical prescriber must be clearly and comprehensively documented in the contemporaneous notes.

12.5 The supplementary prescriber must also inform the independent prescriber when supplementary prescribing.

13. GOOD PRACTICE, ETHICS AND ISSUES COMMON TO ALL PRESCRIBERS

13.1 Accountability

13.1.1 In the event of an adverse incident, prescribers must adhere to the Trust policy (PCT employed staff) or in the case of Community Pharmacists to national policy. National Patient Agency (NPSA). www.npsa.nhs.uk

13.1.2 The non-medical prescriber is accountable for all his/her prescribing decisions.

13.1.3 All nurse and pharmacist independent prescribers must work within their own level of professional competence and expertise and must seek advice and make

appropriate referrals to other professionals with different expertise. Nurses and pharmacists are accountable for their own actions and must be aware of the limits of their skills, knowledge and competence. Nurse must act within clause 6 of the NMC Code of professional conduct: standards for conduct, performance and ethics. Pharmacists must act within the Royal Pharmaceutical Society of Great Britain's Code of Ethics and Standards.

13.1.4 The prescriber should only prescribe for a patient whom she/he has assessed for care on a prescription form bearing the prescribers own unique identification number.

13.1.5 Nurse and pharmacist independent prescribers must ensure that patients are aware that they are being treated by a non medical practitioner and of the scope and limits of their prescribing.

13.1.6 Nurse and pharmacist independent prescribers must not prescribe any medicine for themselves. Neither should they prescribe a medicine for anyone with whom they have a close personal or emotional relationship, other than in an exceptional circumstance. (See NMC's Standards of Proficiency to be Qualified to Prescribe and the RPSGB's Code of Ethics and Standards.)

13.1.7 Any prescriber who writes and signs a prescription assumes full responsibility and clinical liability for it (the employer accepts vicarious liability for employees working within the framework of this policy - see section 9).

13.2 Organisational

13.2.1 All prescribing must be based on The Principles of Good Prescribing (Appendix 6), and follow the agreed employers formulary and guidelines and be cost effective.

13.2.2 In the absence of the patient's original prescriber, when independently prescribing only another prescriber may issue a repeat prescription following an assessment of need, taking into consideration continuity of care.

13.2.3 Prescriptions should not be used to replace stock items.

13.2.4 To enable computer generated prescriptions within GP practices the practice manager / administrator must satisfy themelves that the prescriber is currently registered and verify qualification status.

13.2.5 Practice based prescribers may only issue prescriptions for patients of their own practice.

13.2.6 Prescribers employed by the PCT must only issue prescriptions for the patients of GP practices within the PCT and for GP practices covered by a prescribing contract for which a budget has been agreed.

13.2.7 All prescribers should ensure that prescriptions issued to patients are dispensed according to the individual patient wishes.

13.2.8 Prescribers can prescribe for visitors to the area, including traveling families, provided they are registered with a GP practice as a temporary resident.

13.3 Pharmaceutical Company Representatives

13.3.1 All Non-medical prescribers should be aware of the NHS Ethical Standards for Commercial Sponsorship (Department of Health 2000) and follow own trust policy. Prescribers must manage their relationship with company representatives in a manner that is ethical, equitable and does not impinge on their working day.

- The advertising and promotion of medicines is strictly regulated under the Medicines (Advertising) Regulations 1994, and it is important that non-medical prescribers make their choice of medical product for their patients on the basis of suitability and value for money alone.

- As part of the promotion of a medicine or medicines, suppliers may provide inexpensive gifts and benefits for example – pens diaries or mouse pads. Personal gifts are prohibited and it is an offence to solicit or accept gifts or inducements.

- Companies may also offer hospitality at a professional or scientific meeting or at a meeting to promote medicines, but such hospitality should be reasonable in level and subordinate to the main purpose of the meeting.

- The medicines and Health Care Products Regulatory Agency (MHRA) is responsible for enforcing the legislation on advertising and promotion of medicines. Any complaints about promotional practices should be referred to the MHRA or to the industry self-regulatory body, the Prescription Medicines Code of Practice Authority.

- Free samples must **never** be used for patient care.

- It is recommended that organisations keep a record of hospitality.

- Prescribers should be guided by their professional code of conduct at all times

14. LEGAL AND CLINICAL LIABILITY

14.1 Where a nurse, midwife pharmacist or allied professional 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.

14.2 Nurse independent prescribers are as individuals, professionally accountable to the Nursing and Midwifery Council (NMC) for this aspect of their practice and must act at all times in accordance with the NMC Code of Professional Conduct.

14.3 The NMC recommends that every nurse/midwife prescriber should ensure he/she has professional indemnity insurance, by means of a professional organization or trade union body. Prescribers must also be aware of the level of indemnity insurance offered by their insurer to determine whether it is sufficient for purpose. See clause 9 of the NMC Code of Professional Conduct: Standards for conduct, performance and ethics.

14.4 Pharmacist independent prescribers are individually accountable to the RPSGB and must at all times act in accordance with the RPSGB Code of Ethics and Standards.

15. VERIFICATION OF PRESCRIBING STATUS

15.1 Most queries from pharmacists will be resolved by telephoning the prescriber or the prescribers employer. The organisation will maintain a list of signatories of all non-medical prescribers.

15.2 General queries about the qualification of a prescriber can be made by;

- telephone to the NMC Voice Bank System: 020 7631 3200
- for pharmacists via the internet: www.rpsgb.org.uk/society.

15.3 Community pharmacists should clearly state that they are checking prescribing status of an individual. They will be asked to give the nurse prescriber's name and NMC number.

16. BUDGET SETTING AND MONITORING

16.1 It is the responsibility for the Trust to develop policies and protocols to support the cross organisational working between primary and secondary care.

17. CONTINUING PROFESSIONAL DEVELOPMENT

17.1 All nurses and pharmacists have a professional responsibility to keep themselves abreast of clinical and professional developments. Nurse and pharmacist independent prescribers will be expected to keep up to date with evidence and best practice in the management of the conditions for which they prescribe and in the use of the relevant medicines.

17.2 Non-medical prescribing should take place within a framework of Clinical Governance and Clinical Supervision. The Nurse Prescribing Centre have produced a useful framework to enable Continued Professional Development, (NPC 2001).

17.3 It is the responsibility of each non-medical prescriber to access relevant education, support and training provided by the Trust.

18. AUTHORSHIP

18.1 This policy was produced by Jacqui Laycock, Practice Educator in consultation with the independent and supplementary prescribers of Hull Teaching PCT and is based on the policy produced by Andrew Powell, Professional Lead, for East Riding of Yorkshire PCT.

19. MONITORING

19.1 Clinical Audit Annually
Adverse Incident Reporting system
Patient complaints/PALS

20. REFERENCES

British Medical Association, Royal Pharmaceutical Society (2003) In association with Community Practitioners and Health Visitors Association and Royal College of Nursing - British National Formulary / Nurse Prescribing Formulary.

Department of Health (1998) NHS Executive - Nurse Prescribing – A Guide for Implementation.

Department of Health (2000) NHS Executive - Commercial Sponsorship – Ethical Standards for The NHS.

Department of Health (2002) - Extending Independent Nurse Prescribing within the NHS in England – A Guide for Implementation.

Department of Health (2003) Supplementary Prescribing By Nurses And Pharmacists Within The NHS in England - A guide for implementation.

Department of Health (2006) Improving Patients Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England.

National Prescribing Centre (2001) Maintaining Competency in Prescribing – An outline framework to help nurse prescribers.

National Prescribing Centre (2004) - Maintaining Competency in Prescribing – an outline framework to help allied health professional supplementary prescribers.

National Primary Care Trust Development Programme (2004) - Operational Policy for Non Medical Prescribing.

Nursing and Midwifery Council (2006) - Code of Professional Conduct.

21. REVIEW

21.1 This policy will be reviewed annually.

Author: Jacqui Laycock
Title: Practice Educator
Date: August 2007

Approved by: Adult Provider Governance Group Date: 19th November 2007
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Review by: 19th November 2008 (annually)

APPENDIX 1

Guidance on Clinical Management Plans for Supplementary Prescribing

Responsibilities within Supplementary Prescribing

The working definition of supplementary prescribing is “a voluntary partnership between an independent prescriber and a supplementary prescriber to implement an agreed patient-specific Clinical Management Plan with the patient’s agreement”.

Within this voluntary partnership the independent prescriber is responsible for:

- The initial clinical assessment of the patient, formulation of the diagnosis and determining the scope of the clinical management plan
- Reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review
- Providing support and advice to the supplementary prescriber as requested
- Carrying out a review of patient’s progress at specified intervals
- Sharing the patient’s records with the supplementary prescriber

The supplementary prescriber is responsible for:

- Prescribing for the patient in accordance with the clinical management plan
- Monitoring and assessing the patient’s progress as appropriate to the patient’s condition and the medicines prescribed. Working at all times within their clinical competence and Code of professional Conduct and consulting the independent prescriber as required.
- Accepting professional accountability and clinical responsibility for their prescribing practice
- Passing prescribing responsibility back to the independent prescriber if clinical reviews are not carried out as specified in the clinical management plan or if the patient’s condition no longer falls within their competence
- Recording prescribing contemporaneously in the shared patient record or as soon as possible

The Clinical Management Plan

A Clinical Management Plan relating to a named patient and that patient's specific conditions must be in place before supplementary prescribing can take place. A clinical management plan (written or electronic) must include:

- Name of individual patient
- The patient's specific conditions to be covered by the clinical management plan
- Known allergies
- Current medication
- Reference to the medicines that may be prescribed by the supplementary prescriber and the circumstances within which the supplementary prescriber can vary dose, frequency and formulation of the specified medicines
- Circumstances in which the supplementary prescriber should refer back to the independent prescriber
- Date on which supplementary prescribing commences and the date of review, which should be a maximum of twelve months
- Formal agreement to the plan of the independent and supplementary prescribers and the patient
- Arrangements for the notification of any adverse drug reactions

Where appropriate it is desirable that the clinical management plan makes reference to published national or local guidelines and should draw attention to the relevant part of the guideline, clearly identifying the range of relevant medicines to be used in the patient's treatment. There should be easy access to these guidelines.

Clinical Management Plan

Name of Patient NHS Number	Address
Date of Birth	Allergies
Medical History	Current Medication
Independent Prescriber(s)	Supplementary Prescriber(s)
Condition(s) to be treated	Aim of treatment
Treatment plan	
Preparation	Dose Schedule
Guidelines supporting treatment plan	Review and monitoring requirements
Documentation and record keeping	Referral criteria and ADR reporting
Signed agreement of independent prescriber(s) Date	Signed agreement of supplementary prescriber(s) Date
Date agreed with patient carer:	
Review date:	

This is an example template and can be adapted according to individual specialist practice.

APPENDIX 2

Prescription Pad Procedure

1. Prescription Pads can be ordered for staff once they have completed the Nurse Prescribers qualification.

2. Upon qualification the Higher Education Institute will notify the PCT, staff must notify their relevant non medical prescribing leads.

3. The PCT will notify the Prescription Pricing Authority (PPA) of the newly qualified prescriber by completing a Notification Form.

4. Prescription Pads cannot be ordered until 10 days after the PPA have been notified of the new prescriber.

5. A copy of the notification form and the qualification certificate will be sent to the Clinical Manager for the locality in which the prescriber works. These documents will be stored securely within the locality.

6. If there is a change in circumstances, ie change of name or a nurse leaves the employment of Hull Teaching PCT, their clinical manager must inform the non medical prescribing lead for their speciality who will notify the PPA using Annex A3.

7. Once 10 days has elapsed, an order will be made for 4 Prescription Pads for the Nurse Prescriber by completing the Proforma for Ordering FP10CN forms. Once completed, the form must be emailed to manchesternhsteam@astron.co.uk

8. The Prescription Pads will be delivered to the Despatch Manager at Health House, Willerby, who then contacts the PCT prescription pad administrator, for the collection of Hull Teaching PCT prescription pads. Once received the administrator will contact the non-medical prescriber who will then be able to collect their Prescription Pads.

9. The Despatch Manager at Health House will dispatch prescription pads to practice nurse independent and supplementary prescribers.

10. The clinical manager may collect prescription pads on behalf of the prescribers within their Locality.

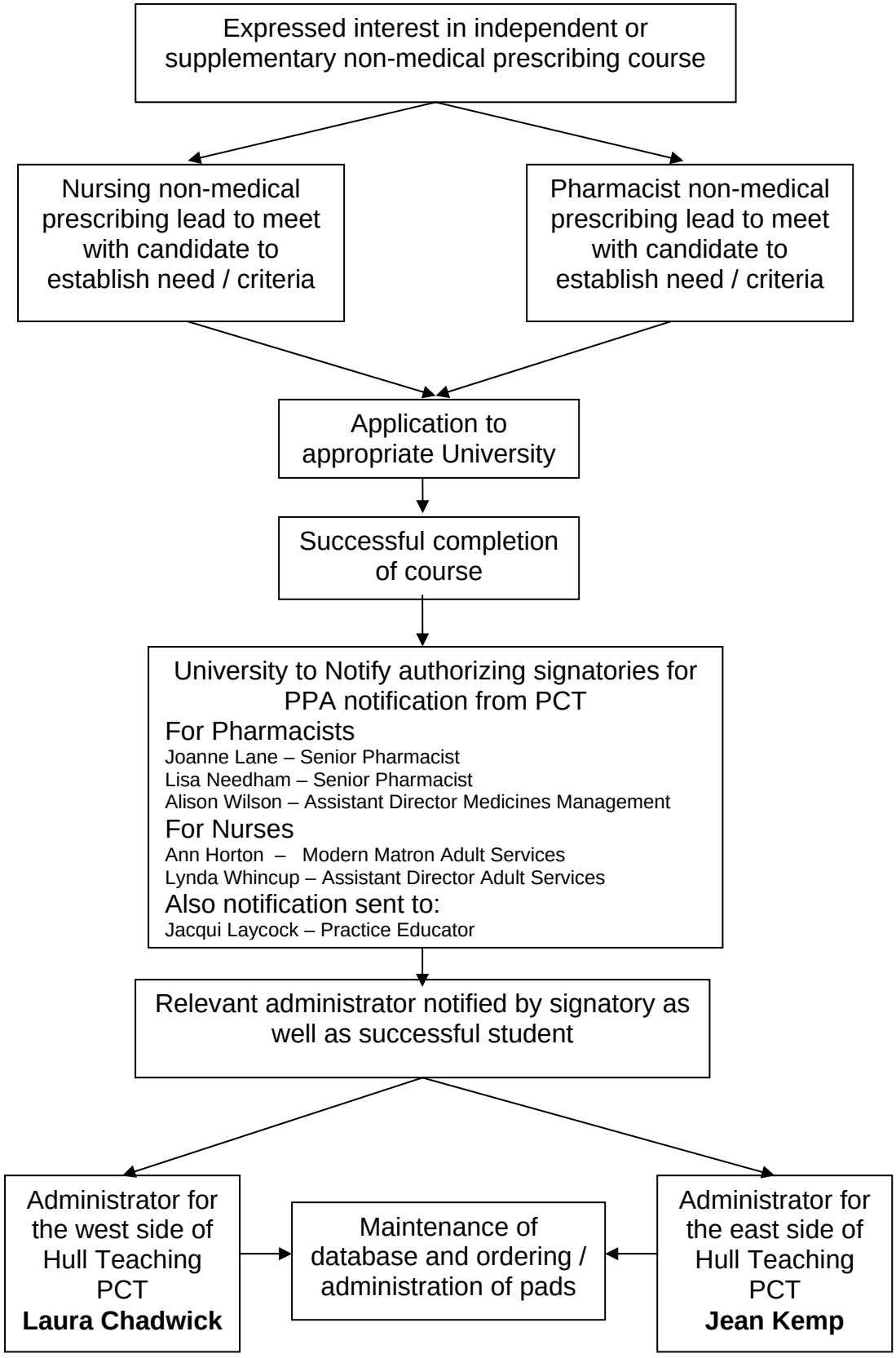
11. The Prescription Pads will be recorded by their serial numbers and stored in a locked / secure cabinet.

12. Prescription Pads will be issued upon request and must be signed for.

13. As soon as a non-medical prescriber has collected their last Prescription Pad in stock a further order will be made to ensure that pads are always in stock.

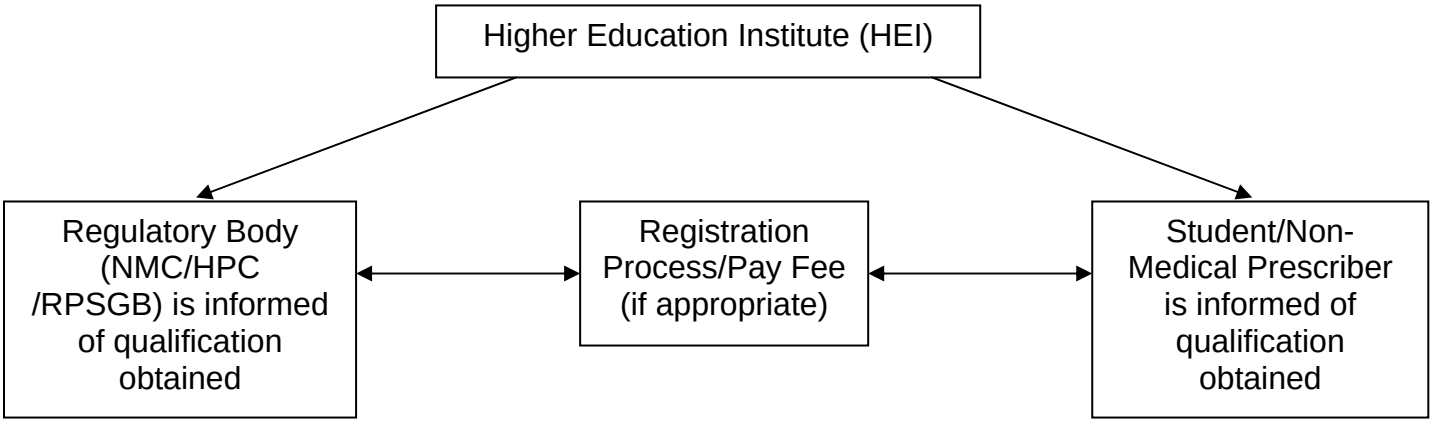
14. The ordering and shredding of new pads will be the responsibility of the prescription pad administrator and a witness who will document and sign a disposal form following shredding.

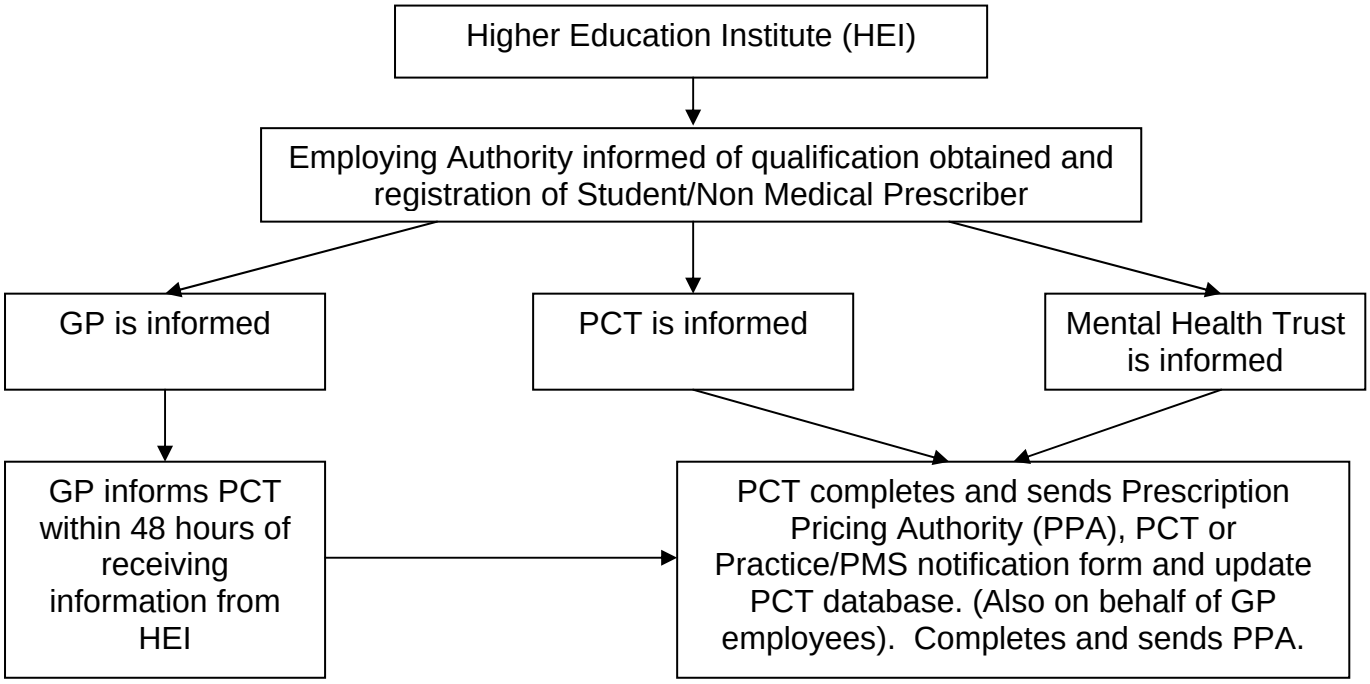
From Completion of Prescribing Programme to Prescribing



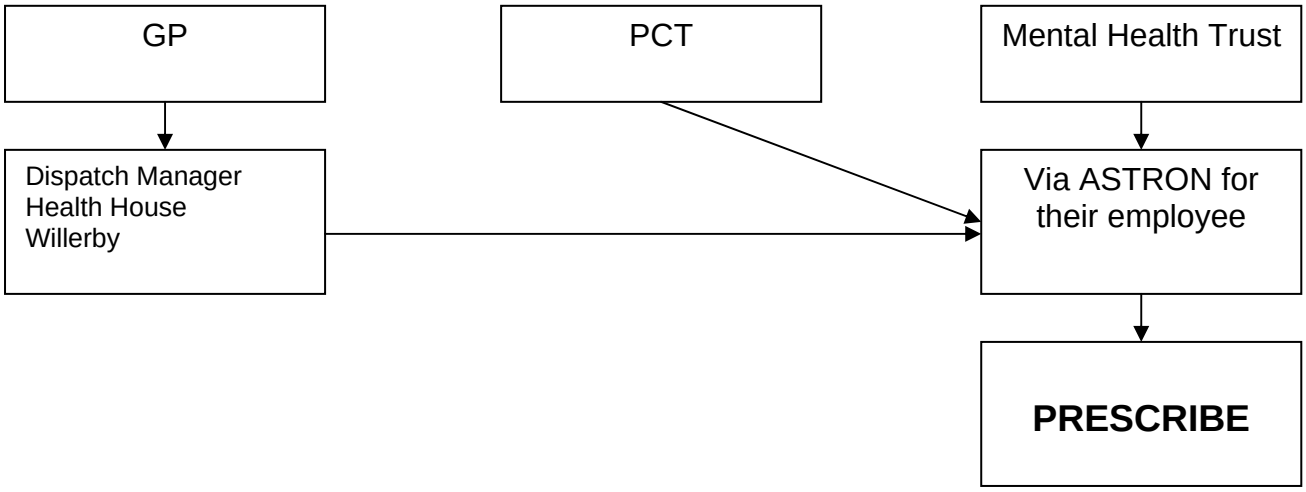
NB as independent and supplementary prescribing becomes available to other professions the processes will remain the same with identified personnel as contacts.

From Completion of Prescribing Programme to Prescribing





Ordering of Prescription Pads



APPENDIX 3

NHS

Prescription Pricing Authority

Form for Notification of Nurse/Supplementary Prescriber Amendments

Form Submitted by: PCT ☐ Agency ☐ Agency Name ……

Name of PCT …… PCT Code ……

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

Or e-mail: Prescription.Information@PPA.NHS.UK

Facsimile: 0191 2035001 **Please ☑**

PROFESSION TYPE				**EMPLOYED BY/CONTRACTED TO**	
Nurse/Midwife	☐	Optometrist	☐	Practice	☐
Pharmacist	☐	Physiotherapist	☐	PCT	☐
Podiatrist	☐	Radiographer	☐	CNPC	☐

UPDATE TYPE			
New Prescriber to your organisation	☐	Change of qualification (Nurse only)	☐
Prescriber working for additional Practice/PCT/CNPC	☐	Prescriber leaving Practice/PCT/CNPC	☐
Change of Surname	☐	Change of Title	☐
Change of Prescriber Code (Nurse only)	☐	Change of Other details	☐

	Deletion		**Addition**	
Name	Surname	Initials	Surname	Initials
Prescriber Code				
Title (Mr/Mrs/Miss/Ms/Sister)				
Qualification (nurse only)	DN/HV Formulary	☐	DN/HV Formulary	☐
	Extended Formulary/Supplementary Prescriber	☐	Extended Formulary/Supplementary Prescriber	☐
Organisation Code (PCT/Practice/CNPC)				
Address				
Effective Date				

NB You must allow the PPA 3 working days to process the information before ordering prescription forms from Astron and where possible inform the PPA 1 month prior to prescriber's start date.

Signature.....(Authorised Signatory) Telephone Number.....

Please Print .....(PCT/Agency Officer) Date ……..

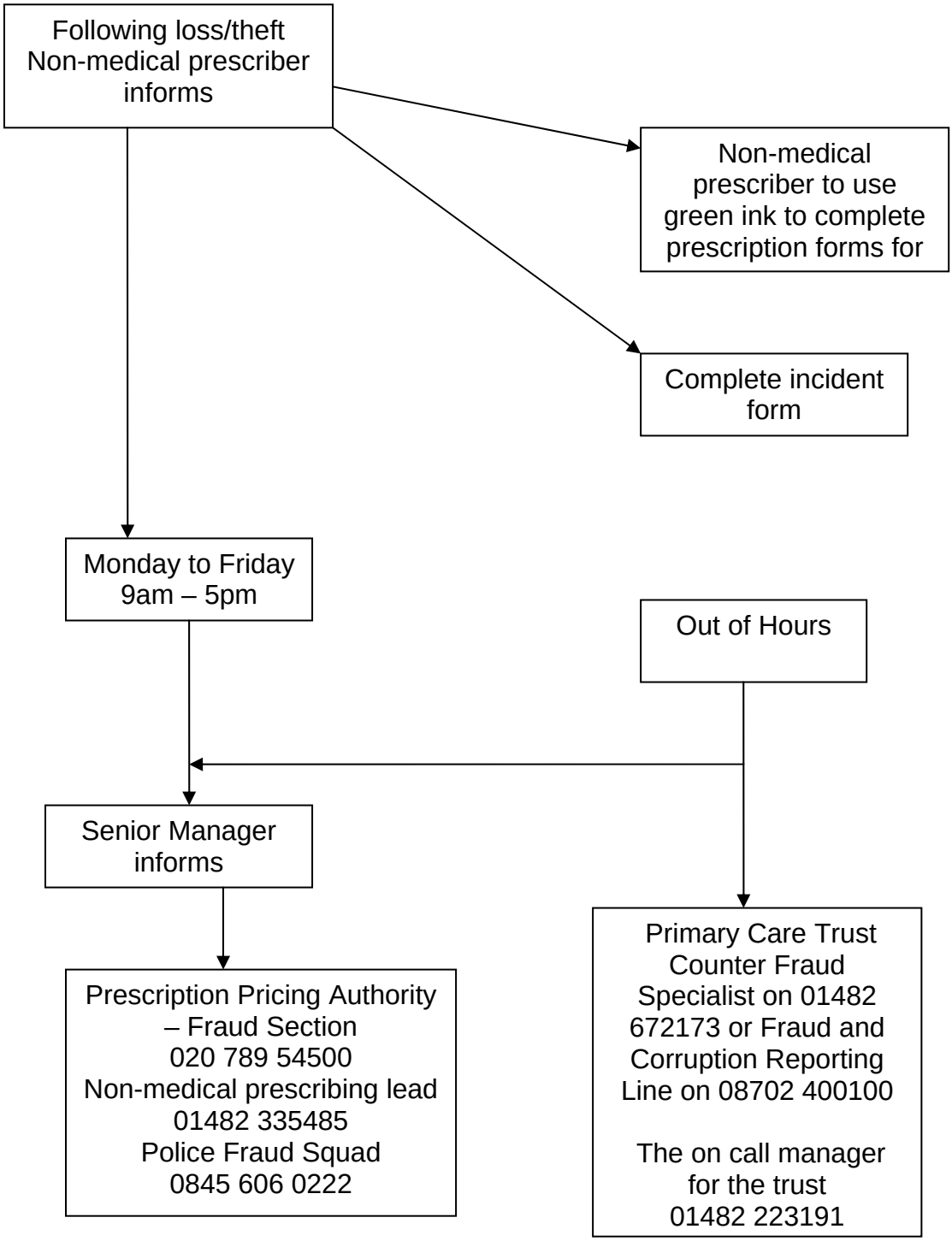
APPENDIX 4

Prescription Pad Audit

Serial Numbers	Nurses Name & site	Date collected from Highlands Health Centre	Received by	Date	Signed	Shredded by	Witnessed by	Date

APPENDIX 5

Procedure for the Loss or Theft of Prescriptions



APPENDIX 6

Seven Principles of Good Prescribing

1. Examine the holistic needs of the patient.
   Is a prescription necessary?

2. Consider the appropriate strategy.

3. Consider the choice of product.

4. Negotiate a ‘contract’ with and achieve concordance with the patient.

5. Review the patient on a regular basis

6. Ensure record keeping is accurate and up to date.

7. Reflect on your prescribing.

APPENDIX 7

Prescribing Fax

Date: ……..

This fax contains information on item(s) prescribed by a non-medical prescriber for a patient in this practice. **Please ensure that this information is entered onto the patient's records** and brought to the attention of the General Practitioner.
Thank you for your assistance.

PATIENT DETAILS	
Name:	**Date of Birth:**
Address:	
GP	
PRESCRIBED ITEMS	
INDICATION FOR PRESCRIPTION	
ADDITIONAL INFORMATION	
NON MEDICAL PRESCRIBER DETAILS	
Name:	Specialty (eg District Nurse, Pharmacist)
Base:	Tel No:

Signature ……

APPENDIX 7

Disposal of Controlled Drugs in the Community (NPC guidance)

The following text outlines Good Practice recommendations reference Disposal, Destruction and Transportation of Controlled Drugs, it is offered in an advisory capacity to Nurses Working in the Community.

Disposal/Destruction of Controlled Drugs

Good practice:
CDs no longer required.
Prescribed drugs including CDs are the property of the patient and remain so even after death. However, it is illegal to possess CDs that have not been prescribed for you. In the first instance the patient/patient's relatives should be advised that all CDs no longer required should be returned to a pharmacy for safe destruction.

It should not normally be the responsibility of community nurses to become involved in the disposal of unwanted CDs. However, there may be occasions when it is appropriate for nursing staff to become involved in the recovery/ disposal of CDs.

A possible staged approach would be:

• If return by relatives/next of kin is not practical or possible then the following action could be taken:

• The nurse with another member of the nursing team acting as a witness disposes of CD in an appropriate and safe manner. This should be within an agreed local Standard Operating Procedure (SOP) and should include appropriate record keeping in patient's notes.

Or

• The nurse could take the unwanted CDs to local community pharmacy for safe destruction, who would also be asked to countersign the patient's nursing record.

Transportation
Good practice:
Nurses should not routinely transport CDs. This should only be undertaken in circumstances where there is no other reasonable mechanism available. CDs should be kept out of sight during any period of transportation.

Source: National Prescribing Centre A guide to good practice in the management of controlled drugs in primary care (England) P.P. 57/58 Feb 2007.