Understanding developments in non-medical prescribing

AUTHOR Fiona Culley, LLM, BSc, RN Cert Ed, is senior lecturer, non-medical prescribing, University of Hertfordshire


As part of the government’s NHS modernisation programme much attention has been given to patient safety, improving patient access to NHS prescription medicines and making better use of nurses’ professional skills. This article aims to describe the current prescribing options for nurses and provides an indication of the likely situations in which nurses (and others) could prescribe.

Ensuring patient safety and identifying the potential to develop and maintain individual competence must remain at the core of any decision to select new prescribers, as according to the Department of Health (2003a), prescribing error is potentially the most serious type of medication error. Prescribing is therefore strictly regulated by numerous pieces of legislation. The legal framework for non-medical prescribing lies principally within the Medicines Act 1968, the Medicinal Products: Prescription by Nurses etc Act 1992, The Health and Social Care Act 2001, and a series of orders (statutory instruments) that amend the Prescription Only Medicines Order, NHS Act 1997, and pharmaceutical services regulations so that suitable arrangements can be made for lawful prescribing and dispensing.

Guidance from the DoH contains detailed information on the criteria for non-medical prescribing in England, including educational preparation for prescribers (DoH, 2002; 2003b; 2005; NHS Modernisation Agency and DoH, 2005). The DoH website has comprehensive information on all aspects of prescribing and is regularly updated (Box 1).

Identifying potential prescribers

A starting point for identifying potential non-medical prescribers is searching the literature for evaluative studies to inform future developments and consider implications for practice. When nurse prescribing was first proposed in the Crown report (DoH, 1989) it was envisaged that the benefits would include improved use of patients’ and nurses’ time and greater clarification of professional responsibilities. These have remained a constant theme through the history of nurse prescribing.

Much has been documented about the perceived advantages and disadvantages of non-medical prescribing. Of particular note is that national research evaluating the first two years of extended formulary nurse prescribing (Latter et al, 2005) shows that it is largely viewed positively by nurses, patients and doctors, and has a positive impact on patient care because of improved access. This echoes an earlier national evaluation of nurse prescribing (Luker et al, 1997), which demonstrates significant benefits to patients, nurses, GPs and pharmacists, including time savings. This is despite some of the limitations of the formulary approach and access to electronic prescribing.

Prioritising candidates for training

While some nurses may never have the opportunity or need to prescribe, others are accepting and developing prescribing roles. These can be independent and supplementary (Box 2). Despite the different roles, common issues may help prioritise selection for non-medical prescribing training. These have been summarised (National Prescribing Centre, 2005) as clinicians who:

- Run their own clinics or services;
- Normally work in isolation from other prescribers (although to a lesser extent with supplementary prescribers who need to work in partnership with an independent prescriber);
- Could complete episodes of care if they were able to prescribe;
- Are likely to be able to prescribe for more than one medical condition;
- Normally work in isolation from other prescribers (although to a lesser extent with supplementary prescribers who need to work in partnership with an independent prescriber);
- Could complete episodes of care if they were able to prescribe;
- Are likely to be able to prescribe for more than one medical condition;
- Normally work in isolation from other prescribers (although to a lesser extent with supplementary prescribers who need to work in partnership with an independent prescriber);
- Could complete episodes of care if they were able to prescribe;
- Are likely to be able to prescribe for more than one medical condition;
- Normally work in isolation from other prescribers (although to a lesser extent with supplementary prescribers who need to work in partnership with an independent prescriber);
- Could complete episodes of care if they were able to prescribe;
- Are likely to be able to prescribe for more than one medical condition;
- Normally work in isolation from other prescribers (although to a lesser extent with supplementary prescribers who need to work in partnership with an independent prescriber);
- Could complete episodes of care if they were able to prescribe;
- Are likely to be able to prescribe for more than one medical condition;
Hold additional qualifications whereby their professional expertise would facilitate prescribing for specified medical conditions.

Prescriber eligibility
When nurse prescribing was first implemented in 1994, it was confined to nurses working in the community or GP practices who held a health visitor or district nurse qualification. That meant many nurses who regularly made diagnostic decisions were prevented from offering a complete care package because they could not prescribe.

Section 63 of the Health and Social Care Act 1994 changed this, allowing ministers, by order, to designate new categories of prescriber and determine related conditions. In 2002, following the Crown II report (DoH, 1999) further legislation allowed any registered nurse or midwife to become a prescriber, as long as they met eligibility criteria set by the DoH (2002; 2003b; NHSMA and DoH, 2005).

Nurses wishing to become prescribers must be first-level nurses or midwives with valid NMC registration, and normally at least three years’ relevant postregistration experience. They must also have successfully completed the necessary educational preparation at degree level according to ENB (2001) and subsequently NMC (2002) standards. Their specific prescribing qualification must then be annotated on the NMC register before they can prescribe legally.

Eligibility is mainly dependent on individual practitioners having an identified service need and opportunity to prescribe often enough to maintain competency in practice, and having access to a prescribing budget and continuing professional development (CPD). The National Prescribing Centre has developed distinct CPD frameworks for nurses (2001), pharmacists (2003) and allied health professionals (AHPs) (2004) to help them and their managers support and develop prescribing competencies. These are available at the www.npc.co.uk website.

Educational preparation
The necessary educational preparation for nurse prescriber extended formulary (NPEF) independent prescribers and supplementary prescribers comprises of one NMC-approved course at level three (first degree level) of at least 26 taught days, plus 12 days learning and assessment in practice working with a designated medical practitioner (doctor) to supervise and assess prescribing competence. A guide to help doctors prepare for, and carry out, that role is available (NPC, 2005).

There are some variations in the educational preparation required for pharmacists and AHPs, as they are currently confined to supplementary prescribing only at this stage. This is all detailed in the DoH (2005) guidance on supplementary prescribing. However, there are also considerable opportunities for shared learning among different professional groups. Courses for non-medical prescribers are normally funded and commissioned by strategic health authority workforce development directors. Training for independent prescribing from the Nurse Prescribers’ Formulary (NPF) only is incorporated into the specialist practitioner training for district nurses and health visitors.

Independent prescribing
Independent prescribers take responsibility for the clinical assessment of the patient, establishing a diagnosis and clinical management, as well as for prescribing where necessary and the appropriate-ness of any prescription (DoH, 2003b). There are two categories of nurse independent prescriber:

- First-level nurses or health visitors, who can prescribe from the NPF;
- First-level registered nurses or midwives, who can prescribe from the Nurse Prescribers’ Extended Formulary (NPEF).

The nurse prescribers’ formulary
Following the recommendations of the Cumberlege Report (DHSS, 1986) and the first Crown Report (DoH, 1989), the Medicinal Products: Prescription by Nurses etc Act 1992 amended the Medicines Act 1968 to allow district nurses, health visitors or practice nurses with a district nurse or health visitor qualification to prescribe independently from a limited formulary. This was enabled by The Medicinal Products: Prescription by Nurses etc Act (commencement no 1) Order 1994. The NPF includes a limited range of medicines and other treatments such as wound management and stoma care products, and urinary catheters and appliances.

Between 1994 and 2002 this was the only prescribing option available to nurses in the UK. According to NMC registration data around 31,781 nurses are now qualified to independently pre-
Maintaining Competency in Prescribing for the Future of Independent Nurse Prescribers

Use the following points to write a reflection for your PREP portfolio:

- List your place of work and the patient groups you care for;
- Write about how medication is prescribed, supplied and administered to your patients;
- Reflect on the routes of non-medical prescribing and how your patients could be benefit;
- Identify the responsibilities and scope non medical prescribing in your setting;
- How can you follow up this reflection.

The extended formulary

In response to proposals in the second Crown Report (DoH, 1999) further amendments were made to NHS and pharmaceutical regulations in 2002 to allow a second category of independent nurse prescriber to prescribe from an extended formulary. The administrative and procedural steps needed to enable nurses to prescribe independently in this way are outlined by the DoH (2002).

Nurses prescribing from the NPEF must only prescribe medicines (including pharmacy-only and general sales medicines) for specified medical conditions, based on a list judged appropriate by the Committee for Safety of Medicines and Ministers for Nurse Prescribing. Independent prescribing is not suitable for prescribing for complex medical conditions or for patients with several comorbidities. Areas of nursing that suit independent prescribing from the NPEF include minor ailments, minor injuries, health promotion and palliative care.

The NPEF is set out in both the BNF and part XVIII (ii) of the Drug Tariff and can be accessed on the www.prodigy.nhs.uk website where the formulary drugs are linked to the specified conditions and situations for which they are recommended.

In May 2005 further statutory changes added 30 medical conditions and around 60 prescription-only medicines (POMs) to the NPEF. It now includes around 240 POMs and 112 medical conditions. Recent additions include some disorders of the central nervous system, infections (cellulitis and tetanus), poisoning, alcohol withdrawal, and a number of other additions to existing categories. This provides further prescribing opportunities for nurses working in areas such as A&E, critical care and first-contact services. Likely candidates for the NPEF independent prescribing role have been identified as nurse consultants, emergency nurse practitioners, practice nurses, family planning nurses and specialist practitioners (DoH, 2002). However, this list is by no means exhaustive as nursing practice continues to develop and new and altered roles emerge.

The future of independent prescribing

Changes to prescribing legislation are subject to statutory consultation arranged and undertaken by the Medicines and Healthcare products Regulatory Agency (MHRA). At the time of writing, the government’s response to the latest MHRA/DoH consultation (2005a) on future options for independent prescribing by nurses (and a separate consultation for pharmacists) is awaited.

The consultation reviews current models of prescribing and aims to expand nurse prescribing in emergency and acute care in particular. It also considers proposals to extend the range of controlled drugs prescribable by nurses, which are being considered by the Home Office’s Advisory Council on the Misuse of Drugs (ACMD). The most far-reaching proposal is for nurses to prescribe for any medical condition from a full formulary. Some responses to the consultation including those from nursing, pharmaceutical, and medical organisations are available on the www.nurse-prescriber.co.uk website.

Whatever the outcome of the consultation, a number of changes by statutory instrument are required before any policy decisions can be implemented, and it is not envisaged that these would be in place until early 2006 (MHRA, 2005b).

Supplementary prescribing

Supplementary prescribing is ‘a voluntary partnership between the independent prescriber (a doctor or dentist) and supplementary prescriber to implement an agreed patient specific clinical management plan (CMP) with the patient’s agreement’ (DoH, 2002). It is best suited to management of long-term conditions such as asthma, diabetes, cardiovascular disease, mental health, musculoskeletal conditions and gastrointestinal disease and where there is good teamwork.

As a result of yet further amendments to the Prescription Only Medicines Order and NHS regulations, supplementary prescribing was established in 2003 for nurses and pharmacists. Since April 2005 physiotherapists, chiropodists, podiatrists, and diagnostic or therapeutic radiographers have also been authorised to train as supplementary prescribers. The specific details of this are detailed in DoH guidance (DoH, 2005). Further legislative changes are expected later this year to allow optometrists to become supplementary prescribers.
Supplementary prescribers prescribe in partnership with a doctor or dentist (independent prescriber), who remains responsible for the individual’s care. After initial diagnosis and prescription by the independent prescriber, the supplementary prescriber has discretion in the choice of dosage, frequency, product and other variables in relation to the medicines. Therefore supplementary prescribing must be supported by regular (at least annual) clinical review. For safety reasons the independent and supplementary prescriber must have access to a shared patient record.

There is no specific formulary of medicines or limitation on the clinical conditions supplementary prescribers may treat (NHMSA, 2005). Recent restrictions have been lifted to include the following drugs in supplementary prescribing by nurses and pharmacists only: antimicrobials, black triangle drugs, and some controlled drugs.

There is, however, a legal requirement that the medicines are referred to in a written or electronic CMP relating to a named patient and the patient’s specific condition(s). This must be agreed by the independent prescriber, supplementary prescriber and patient before prescribing, and the medicines will be prescribable by a doctor or dentist (independent prescriber) at NHS expense. Sample draft templates for CMPs are available on the DoH website at www.dh.gov.uk/PoliciesAndGuidance. A CMP must include the range of medicines that may be prescribed, and an indication of when the plan will be reviewed by the independent prescriber.

Professional responsibilities
The NPC (2002) has produced a helpful resource preparing nurses and midwives for prescribing responsibilities and reminding them of their legal and professional accountability and duty of care. Those who prescribe must comply with current legislation for prescribing and be accountable for their own practice (NMC, 2004a). As with all other aspects of their practice, nurse prescribers must only act within their level and area of competence, acknowledging the scope and limitations of the role, and communicate this to colleagues and patients. They should also take note of the current NMC position on indemnity insurance, stated within the code of professional conduct (NMC 2004b), and make appropriate arrangements.

In order to promote safe and effective practice and improve quality of care, prescribing needs to be commissioned and developed within a clinical governance framework. There must be clearly defined policies, support mechanisms, audit systems, and job descriptions in place, bearing a number of resource and managerial implications for employing organisations.

Practice implications
Like other aspects of NHS modernisation, successful development of the prescribing role depends on timely identification and planning of service needs, and suitable selection, preparation and continuing professional development of competent practitioners.

Whatever the outcomes of current and future consultation, appropriately responding to new legislation and policy directives for the benefit of patients depends upon flexible and innovative approaches to service provision. Effective non-medical prescribing also requires an assurance by employers, managers, and individual practitioners that suitable mechanisms and strategies are in place to uphold patient safety.

---

**REFERENCES**

- Nursing and Midwifery Council (2004a) Guidelines for the Administration of Medicines. London: NMC.