Independent and Supplementary Prescribing
An Essential Guide
To

Tim, Tom and Kath. The last book . . . . . maybe
Donna, Hope and Oscar. The last book . . . . . definitely
Independent and Supplementary Prescribing
An Essential Guide

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Foreword by

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## Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foreword</td>
<td>vii</td>
</tr>
<tr>
<td></td>
<td>Preface</td>
<td>ix</td>
</tr>
<tr>
<td></td>
<td>Contributors</td>
<td>xi</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td>Chapter 1 Non-medical prescribing: an overview</td>
<td>1</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Chapter 2 Non-medical prescribing in a multidisciplinary team context</td>
<td>7</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Chapter 3 Consultation skills and decision making</td>
<td>17</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Chapter 4 Legal aspects of independent and supplementary prescribing</td>
<td>33</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Chapter 5 Ethical issues in independent and supplementary prescribing</td>
<td>47</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Chapter 6 Psychology and sociology of prescribing</td>
<td>61</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Chapter 7 Applied pharmacology</td>
<td>75</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>Chapter 8 Monitoring skills</td>
<td>97</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td>Chapter 9 Promoting concordance in prescribing interactions: the evidence base and implications for the new generation of prescribers</td>
<td>121</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>Chapter 10 Evidence-based prescribing</td>
<td>135</td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>Chapter 11 Extended/supplementary prescribing: a public health perspective</td>
<td>149</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>Chapter 12 Calculation skills</td>
<td>167</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>Chapter 13 Prescribing in practice: how it works</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td>217</td>
</tr>
</tbody>
</table>
Foreword

The extension of the authority to prescribe has moved on apace since the publication of the Review of the Prescribing, Supply and Administration of Medicines in 1999. Now nurses and pharmacists, as well as doctors and dentists, can prescribe, and they will soon be joined by other health professionals. These rapid developments have set challenges for professional and regulatory bodies and for individual practitioners. However, all concerned have risen to these challenges with energy and enthusiasm. Training programmes are well developed, many nurses and pharmacists have completed training, and the benefits to patients are already being felt.

This book is timely and I would like to congratulate Molly Courtenay and Matt Griffiths on bringing together a group of distinguished contributors who have produced an authoritative and comprehensive account of all aspects of prescribing. I am sure that it will prove invaluable both as a practical guide to new prescribers and a continuing reference source.

I hope that this book will not be seen only as a book for the new prescribing professions. Its thorough examination of all aspects of the prescribing process and the implications of extended prescribing for multidisciplinary teams should also commend it to existing prescribers. It is a valuable text for every professional who is learning to prescribe or who wishes to improve their practice.

I have no doubt that Independent and Supplementary Prescribing will inform and support prescribers and that it will make an important contribution to improvements in both the quality and accessibility of patient care.

Dr June Crown CBE
The introduction of non-medical prescribing has meant that nurses and pharmacists have had to expand their practice and so acquire new knowledge and skills in a number of fields. This new knowledge has had to be applied to the many issues surrounding prescribing in the practice setting. There are currently few books available that provide these prescribers with information to help them in this role. As non-medical prescribing extends to include allied health professionals, the need for such information will increase. This book is aimed at those non-medical professions involved in prescribing medicines.

Chapter 1 provides a general overview of non-medical prescribing and describes the current education and training available for extended independent and supplementary prescribers. Chapters 2–5 examine non-medical prescribing within a multi-disciplinary team context, the different models of consultation that might be used by prescribers and the legal and ethical aspects surrounding prescribing. The psychology and sociology of prescribing, applied pharmacology and monitoring skills are explored in Chapters 6–8. Chapters 9–12 deal with medicines concordance, evidence-based prescribing, prescribing within a public health context and the calculation skills required by prescribers. The concluding chapter describes how independent and supplementary prescribing can be used by non-medical prescribers. The treatment management of patients with dermatological conditions are used as an example. It is hoped that insights gained from this chapter will be applicable to other practice settings.

Each chapter is fully referenced and where appropriate readers are offered suggestions for further reading and other information sources. We hope that this book will make a positive contribution in a very important aspect of patient care.

Molly Courtenay
Matt Griffiths
2004
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Chapter 1

Non-medical prescribing: an overview

Molly Courtenay and Matt Griffiths

In 1986, recommendations were made for nurses to take on the role of prescribing. The Cumberlege Report Neighbourhood Nursing: A Focus for Care (Department of Health and Social Security (DHSS), 1986) examined the care given to clients in their homes by district nurses (DNs) and health visitors (HVs). It was identified that some very complicated procedures had arisen around prescribing in the community and that nurses were wasting their time requesting prescriptions from the general practitioner (GP) for such items as wound dressings and ointments. The report suggested that patient care could be improved and resources used more effectively if community nurses were able to prescribe as part of their everyday nursing practice, from a limited list of items and simple agents agreed by the DHSS.

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DoH) to examine nurse prescribing (Crown Report, DoH, 1989). Dr June Crown was the Chair of this group.

The following is taken from the Crown Report:

*Nurses in the community take a central role in caring for patients in their homes. Nurse are not, however, able to write prescriptions for the products that are needed for patient care, even when the nurse is effectively taking professional responsibility for some aspects of the management of the patient. However experienced or highly skilled in their own areas of practice, nurses must ask a doctor to write a prescription. It is well known that in practice a doctor often rubber-stamps a prescribing decision taken by a nurse. This can lead to a lack of clarity about professional responsibilities, and is demeaning to both nurses and doctors. There is wide agreement that action is now needed to align prescribing powers with professional responsibility.*

DoH (1989)

The report made a number of recommendations involving the categories of items that nurses might prescribe, together with the circumstances under which they might be prescribed. It was recommended that:

*Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol.*

DoH (1989)
The Crown Report identified several groups of patients that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma, patients suffering with post-operative wounds and homeless families not registered with a GP. The Report also suggested that a number of other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, this included improved use of both nurses’ and patients’ time and improved communication between team members arising as a result of a clarification of professional responsibilities (DoH, 1989).

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed (Medicinal Products: Prescribing by Nurses Act 1992). The necessary amendments were made to this Act in 1994 and a revised list of products available to the nurse prescriber was published in the Nurse Prescribers’ Formulary (NPF) (NPF, 2003). In 1994, eight demonstration sites were set up in England for nurse prescribing. By the Spring of 2001, approximately 20,000 DNs and HVs were qualified independent prescribers and post-registration programmes for DNs and HVs included the necessary educational component qualifying nurses to prescribe.

The available research exploring independent nurse prescribing by DNs and HVs indicates that patients are as satisfied, and sometimes more satisfied with a nurse prescribing as they are with their GP. The quality of the relationship that the nurse has with the patient, the accessibility of the nurse and their approachability, the style of consultation and information provided, and the expertise of the nurse are attributes of nurse prescribing viewed positively by patients (Luker et al., 1998). Nurse prescribing enables doctors and nurses to use their time more effectively and treatments are more conveniently provided (Brooks et al., 2001). Time saving and convenience (with regard to not seeing a GP to supply a prescription) are benefits reported by nurses adopting the role of prescriber (Luker et al., 1997). Furthermore, nurses are of the opinion that they provide the patient with better information about their treatment and have reported an increased sense of satisfaction, status and autonomy (Luker et al., 1997; Rodden, 2001).

A further report by Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999 (DoH, 1999). The review recommended that prescribing authority should be extended to other groups of professionals with training and expertise in specialist areas. During 2001, support was given by the government for this extension (DoH, 2001). Funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary.

This formulary included:

- A number of specified Prescription-Only-Medicines (POMs), enabling nurses to prescribe for a number of conditions listed within four treatment areas, i.e. minor ailments, minor injuries, health promotion and palliative care.
- General Sales List (GSL) items, i.e. those that can be sold to the public without the supervision of a pharmacist, used to treat these conditions.
- Pharmacy (P) medicines, i.e. those products sold under the supervision of a pharmacist, used to treat these conditions.
During 2003, proposals by the Medicines and Healthcare Products Regulatory Agency (MHRA, 2003) to expand the Nurse Prescribers Extended Formulary (NPEF) were accepted and the NPEF was extended to include a number of additional conditions and medicines (NPF, 2003). The government also promised that the formulary would be further extended in 2004 to include medicines prescribable by nurses working in first contact and emergency care.

Further legislation was also passed by the Home Office in 2003, allowing nurses to prescribe a number of controlled drugs (CDs). These include:

1. Diazepam, lorazepam, midazolam (schedule 4 drugs) for use in palliative care.
2. Codeine phosphate, dihydrocodeine and co-phenotrope (schedule 5 drugs).

A number of other CDs, included in the proposals set out by the MHRA (2003), are expected to be added to the NPEF in 2004, following Home Office approval. These include pain relief in palliative care and diamorphine in coronary care.

**EDUCATIONAL PREPARATION FOR EXTENDED PRESCRIBERS**

An outline curriculum for the educational preparation for extended independent prescribing was produced by the English National Board (ENB) for Nursing and Midwifery in September 2001 (ENB, 2001). Following the closure of the ENB, the Nursing and Midwifery Council (NMC) have continued to apply the ENB's existing standards and guidance for the approval of higher education institutions (HEIs) with regards to registerable and recordable programmes (Letters; 8 November 2001; 21 March 2002).

The extended independent prescribing programme is 3–6 months in length and includes 25 taught days, additional self-directed study, plus 12 days learning in practice with a medical mentor. The areas of study included within the prescribing module (ENB, 2001) are those general concepts that underpin prescribing. Topics include:

- Consultation, decision-making and therapy including referral
- Influences on and psychology of prescribing
- Prescribing in a team context
- Clinical pharmacology including the effects of co-morbidity
- Evidenced-based practice and clinical governance in relation to nurse prescribing
- Legal, policy and ethical aspects
- Professional accountability and responsibility
- Prescribing in the public health context.

**SUPPLEMENTARY PRESCRIBING**

The introduction of a new form of prescribing for professions allied to medicine was suggested in 1999 (DoH, 1999). It was proposed that this new form of prescribing,
i.e. ‘dependent’ prescribing would take place after a diagnosis had been made by a doctor and a Clinical Management Plan (CMP) drawn up for the patient. The term ‘dependent’ prescribing, has since been superseded by ‘supplementary prescribing’.

Supplementary prescribing is a voluntary prescribing partnership between an independent prescriber (doctor) and a supplementary prescriber (SP) (nurse or pharmacist, to implement an agreed patient-specific CMP with the patient’s agreement (DoH, 2002). Patients with long-term medical conditions such as asthma, diabetes or coronary heart disease, or those with long-term health needs such as anti-coagulation therapy are most likely to benefit from this type of prescribing.

Unlike independent prescribing, there are no legal restrictions on the clinical conditions for which SPs are able to prescribe. Nurses adopting the role of SP will be able to prescribe:

- All GSL and P medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All POMs with the current exception of CDs – the Home Office are currently deliberating on a consultation to potentially instigate changes in the law to make this possible.
- ‘Off-label’ medicines (medicines for use outside their licensed indications), ‘black triangle’ drugs and drugs marked ‘less suitable for prescribing’ in the British National Formulary (BNF).
- Unlicensed drugs may only be prescribed if they are part of a clinical trial with a clinical trial certificate or exemption (this may change following proposals set out by the MHRA (2004) enabling SP to prescribe unlicensed medicines).

Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists. However, the government has promised that other professions allied to medicine will be able to prescribe as of 2004.

Training for supplementary prescribing is based on that for extended independent prescribing. For nurses, the taught element of the course is 26/27 days, of which a substantial proportion is face-to-face contact time, although, other ways of learning, such as open and distance learning (DL) formats, might be used. Students are also required to undertake additional self-directed learning and 12/13 days learning in practice with a medical prescriber.

Training for extended independent prescribing is combined with that for SP in the majority of HEIs. The Royal Pharmaceutical Society of Great Britain (RPSGB), responsible for validating SP programmes for pharmacists has acknowledged that as between 60% and 70% of the SP curriculum will be common to both nurses and pharmacists, institutions running the SP curriculum for nurses provide an ideal opportunity for shared learning. Therefore, a number of HEIs run the combined extended independent/supplementary prescribing programme for nurses and pharmacists. Nurses qualify as both extended independent and SPs upon successful completion of the course and pharmacists qualify as SPs.

In England, the extended independent prescribing module attracts 20 credit accumulation and transfer scheme (CATS) points at level 3. The combined extended
SP programme awards an additional 10 credit accumulation and transfer scheme (CATS) points, i.e. a total of 30 CATS points. This is in contrast to regions with devolved governments (e.g. Northern Ireland). In these instances, HEIs are able to award a greater number of credits. One such institution in Northern Ireland is currently awarding 60 CATS points to nurses undergoing prescribing preparation.

Entry requirements for extended independent and SP programmes include:

- Registration with the NMC as a first level Nurse or Midwife or, for pharmacists, current registration with the RPSGB and/or the Pharmaceutical Society of Northern Ireland (PSNI).
- The ability to study at level 3.
- At least 3 year’s post-registration clinical nursing experience (or part-time equivalent). For pharmacists, the level of relevant knowledge and expertise is dependent upon the nature of their practice and the length of their experience.
- Have a medical prescriber willing to contribute to the students 12/13 days learning in practice (including the assessment process), and supervised prescribe post-qualifying.
- Agreement by their employing organisation to undertake the programme, a period of supervised practice, and continuing professional development (CPD).
- Commitment by their employer to enable access to prescribing budgets and other necessary arrangements for prescribing in practice.
- Occupy a post in which they are expected to prescribe (RPSGB, 2003; ENB, 2001).

For further discussion of supplementary prescribing see Chapter 2.

**CONCLUSION**

Until recently, the development of non-medical prescribing has been slow. It was first considered by the government for nurses in 1986. However, as of 2001, the introduction of extended independent and SP has been considered for other healthcare professionals (including other 1st level nurses as well as those with a DN/HV qualification).

Training for independent extended prescribing for nurses commenced in 2002. Nurses are now able to prescribe independently from a list of medicines (including CDs) for an array of conditions and the government has promised that the NPEF will be further extended to include prescribing in first contact and emergency care. Independent prescribing for pharmacists is currently under consideration.

Training for supplementary prescribing was introduced for nurses and pharmacists in 2003. SPs can prescribe from virtually the whole of the BNF and may include CDs as of 2004. Other groups of healthcare professionals are to be considered by the government for prescribing this year. DoH funding for extended independent and supplementary prescribing has been extended until 2005/2006 and the government aims to train 10,000 nurses and 1000 pharmacists during this period.
Independent and supplementary prescribing

References


