### Non - Medical Prescribing policy and Clinical Governance Framework Policy

Non - Medical Prescribing policy and Clinical Governance Framework

1. Strategic Context

1.1 Legislation to enable prescribing by non-medical staff is a key component of NHS modernisation and improving patient care.

1.2 This document sets out how NMP is managed within SFT. In doing this it:

* reiterates SFTâ€™s commitment to the development of NMP as an important component of effective and efficient service delivery
* defines what is meant by NMP and the staff groups to which it relates
* identifies standards for NMP
* details the clinical governance framework in which NMP operates within SFT.

2. Definitions and Staff Groups Involved

2.1 Non-medical prescribing

Non-medical prescribing is prescribing by specially trained nurses, optometrists, pharmacists, physiotherapists, podiatrists and radiographers, working within their clinical competence as either independent and/or supplementary prescribers.

All non-medical prescribing is underpinned by legislation and regulatory standards. Accordingly, all non-medical prescribers must record their qualification with their professional regulator and have a responsibility to remain up to date with the knowledge and skills that enable them to prescribe competently and safely.

2.2 Independent Prescribing (IP)

Independent prescribing is prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. In practice there are 2 distinct forms of non-medical independent prescriber.

2.2.1      An independent prescriber may currently be a specially trained nurse, pharmacist or optometrist[1] and can prescribe any licensed medicine within their clinical competence. Nurse and pharmacist independent prescribers can also prescribe unlicensed medicines and controlled drugs.

2.2.2      Community Practitioner Nurse Prescribers are a distinct group under independent prescribers. They consist of district nurses, health visitors and school nurses who, having completed the necessary training, are allowed to independently prescribe from a limited formulary called the Nursing Formulary for Community Practitioners which includes over-the-counter drugs, wound dressings and appliances and can be found in the BNF.

2.3 Supplementary Prescribing (SP)

Supplementary prescribing is a voluntary prescribing partnership between a doctor or dentist and a supplementary prescriber, to prescribe within an written patient-specific clinical management plan (CMP) agreed with a doctor and with the patientâ€™s agreement. A supplementary prescriber can prescribe any licensed or unlicensed medicine, including controlled drugs, for any condition within their competence provided it forms part of the written CMP.

Nurses, optometrists, pharmacists, chiropodists and podiatrists, physiotherapists and radiographers may currently train as SPs and once qualified may prescribe any licensed or unlicensed medicine, including controlled drugs, for any condition within their competence according to the CMP.

2.4 Appropriate Use of IP/SP

Non-medical prescribing is one method of several through which supply and/or administration of medicines are authorised within SFT (see Appendix 1). It is important that the most effective, efficient, safe and legally appropriate systems are chosen for prescribing and supplying medicines to patients within the Trust and advice should be sought from the Chief Pharmacist.

3. Implementation Within SFT

3.1 Identifying Areas Appropriate For Non-medical Prescribing

3.1.1 All proposals relating to development of NMPs must demonstrate:

* **patient safety**
* **maximum benefit to patients in terms of quicker and more efficient access to medicines for patients**
* **better use of skills of non medical professionals**

These key principles will be used by the Trust to prioritise applications for NMP development.

3.1.2 In addition, services and Directorate Management Teams (DMTs) must also consider the following:

* Whether NMP provides the best means of service delivery in a given situation.
* Availability of a medical prescriber willing and able to contribute to and supervise the traineeâ€™s â€˜learning in practiceâ€™ element of training (Designated Medical Practitioner (DMP)). Guidance entitled â€˜Training non-medical prescribers in practice â€“ a guide to help doctors prepare for and carry out the role of designated medical practitionerâ€™ is available on the National Prescribing Centre website and should help to inform the selection of DMPs.
* Training of staff to undertake NMP involves a specific programme of preparation at degree level, comprising at least 26 taught days at a Higher Education Institution (HEI) plus 12 days â€˜learning in practiceâ€™. This is usually spread over a period of approximately 6 months. As a consequence it is essential that services, potential NMPs and DMTs consider carefully the relative merits of NMP and ensure that other options (such as patient group directions (PGDs)) are used wherever appropriate. Advice on this can be obtained from the Chief Pharmacist (NMP lead for SFT).
* In general, where services to patients involve only a very limited range of medicines to be either supplied or administered by the practitioner themselves, a PGD may be more appropriate. Where services involve a wide range of drugs and/or where administration is by a nurse/midwife other than the practitioner (so-called â€˜secondary administrationâ€™) NMP would be required.
* Intentions to develop NMP services must be included in the department service plan.

### 3.1.3 The Role of the Designated Medical Practitioner (DMP)

A designated medical practitioner (DMP) is a medical practitioner who directs and supervises a non-medical prescriberâ€™s period of learning in practice â€“ a required element of non-medical prescribing qualifications. They will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies.

Each non-medical prescriber student must have a designated medical mentor as their DMP who must be a registered medical practitioner. It is anticipated that the potential student will identify such a DMP whom they have a good working professional relationship based in their clinical area.

The DMP must be a registered medical practitioner who

* Has normally had at least three years medical practice and prescribing responsibility for a group of patients/clients in the relevant field of practice.
* Has the support of the employing Trust to act as a designated medical mentor who will provide support and opportunities to develop competence in prescribing practice.
* Has some experience of training in teaching and/or supervising in practice.
* Normally works with the student prescriber.

The DMP has a crucial role in educating and assessing the non medical prescriber. This involves:

* Establishing a learning contract with the student prescriber following the university approved template.
* Planning a learning programme which will provide the opportunity for the trainee to meet their learning objectives and gain competency in prescribing.
* Facilitating learning by encouraging critical thinking and reflection.
* Providing dedicated time and opportunities for the student to observe how the DMP conducts a consultation/interview with patients and/or carers in the development of a management plan.
* Allowing opportunities for the student to carry out consultations and suggest clinical management and prescribing options which are then discussed with the DMP.
* Helping ensure the student prescriber integrates theory with practice.
* Taking opportunities to allow in depth discussion and analysis of clinical management using a random case analysis approach, when patient care and prescribing behaviour can be examined further.
* Assessing and verifying that by the end of the course, the student is competent to assume the prescribing role.

The Higher Education Institution (HEI) providing the training course will provide information and a half day briefing to all DMPs.

3.2 Applying For Trust Approval For NMP Development

Where NMP is considered to be appropriate, services must seek Trust approval in accordance with the Trust Practice Development Strategy and Expanded Practice Framework before applications are made for NMP training.

Applications to extend practice must be made using the Expanded Practice Framework documentation (available via ICID) and will be reviewed by the Expanded Practice Validation Group and Increasing Access to Medicines Panel (IATMP), a sub-group of the Drugs and Therapeutics Committee (DTC), to ensure that the most effective option for supply of medicines to patients has been selected. Only once approval has been given should NMP training/implementation start.

3.3 Selection of Staff for NMP Training

* Applicants must be a 1st level Registered Nurse, Registered Midwife, Registered Pharmacist, Registered Optometrist or, for supplementary prescribing only, an AHP, and fulfil the legal criteria for eligibility to prescribe.
* Nurses/midwives must have the ability to study at Level 3 (degree level), pharmacists to study at a minimum of QAA level 3 and AHPs at a minimum of level 3.
* Nurses/midwives must have at least three years post-registration professional clinical experience, pharmacists at least 2 years experience as a pharmacist, following their pre-registration year and AHPs must have at least 3 years relevant post-qualification experience (or part-time equivalent for each professional group). All applicants must have at least 1 years experience in the specialty in which they will be prescribing.
* Applicants, managers and DMPs must complete the Trust application form â€˜Application to train as a NMPâ€™ (see appendix 2).
* In most circumstances, applicants must be at Band 6 or above.
* Applicants must provide evidence within the application form of DMP agreement to contribute to and supervise the applicantâ€™s â€˜learning in practiceâ€™ element of training.
* Applicants must provide evidence of ongoing continuing professional development (CPD).
* The line manager and DMP must ensure that the applicant planning to become a NMP has the knowledge and skills to provide the role. The course does not teach clinical knowledge and its application to practice. This is assessed by the DMP during the 12 days supervised practice required by the course.
* Applicants must have a current Disclosure and Barring Service (DBS (prev. CRB)) check.

An overview of this process is given in Appendix 3.

Where approval is given by the Expanded Practice Validation group the staff member should apply for course funding and a place on the relevant course through the Lead for Learning Environments and Professional Development. NB. The Trust Lead for NMP (Chief Pharmacist) MUST be informed of the application.

3.4 Approval to Practice as a NMP Within SFT

Before commencing prescribing activities all NMPs MUST register their prescribing intentions with the Trust. This must be done using the form given in Appendix 4.

NMPs must be:

* A registered nurse/midwife, pharmacist, optometrist or AHP who has completed a programme of training accredited by their relevant professional body.
* Registered as an independent non-medical prescriber and/or supplementary prescriber on the appropriate professional register.
* Employed by Salisbury NHS Foundation Trust or partner organisation in a suitable position that has an agreed scope for practising as an IP or SP (see 3.2).
* Ratified to practice as non-medical prescriber within SFT by the Drugs and Therapeutics Committee, the relevant Professional Lead and the Chief Pharmacist.

NB Staff registered as NMPs with their respective professional body who have been practising in other Trusts must complete the application to be included on the Trust Register of NMPs (Appendix 4) and receive confirmation from the Trust NMP Lead before they undertake prescribing activities within SFT.

An overview of this process is given in Appendix 5.

Any NMP planning to extend their prescribing to a new clinical speciality must seek Trust approval in accordance with the Trust Practice Development Strategy and Expanded Practice Framework before commencing extended prescribing practices (see 3.2).

In addition, such staff must undertake a further 2 days practice under the supervision of a DMP in the relevant area of practice. It is considered good practice to complete a reflective practice diary during this time to ensure training needs are identified and met. The DMP must confirm the NMPâ€™s competence to carry out the extended role by countersigning a new application form (Appendix 4) for approval, before extended prescribing commences.

A new application form (Appendix 4) is also required from NMP supplementary prescribers where the responsible clinician named in the clinical management plans leaves the Trust and a replacement is identified. The NMP must inform the Trust Lead for NMP immediately. It is unlawful for a supplementary prescriber to practice without a responsible clinician with continuing responsibility for the NMPâ€™s patients.

Once an NMP has received approval to practice by the Trust, their name, area of practice and signature will be entered on to the SFT register of NMPs. For SPs, the name of the responsible clinician must be entered on the register beside the SPâ€™s name and all Clinical Management Plans (CMP) must be signed off by the clinician and SP. The Trust template for CMPs is given in Appendix 6.

Applications for training and approval to practice will be reviewed on behalf of the DTC by the IATMP. Decisions will be notified to the applicant and manager by e-mail and minuted by the DTC.

3.5 Register of NMPs Approved for Practice Within SFT

A register of names, areas of practice for each NMP will be held by the Chief Pharmacist (NMP Lead for SFT). Copies of signatures will be held by the Pharmacy Department at Salisbury District Hospital. All NMPs must ensure their current signature is held by the pharmacy department.

4. Prescribing and dispensing

4.1 Standards

4.1.1      The quality and safety of health care provided to patients is a priority for SFT. NMP is a developing and expanding role and it is important that it is conducted in a safe and effective manner at all times. Ensuring patient safety is paramount.

4.1.2      All prescribing must be conducted in accordance with standards for prescribing practice issued by the relevant professional body. For nurses and midwives, these have been published in the document â€˜Standards of proficiency for nurse and midwife prescribersâ€™ NMC June 2012.

4.1.3      NMPs may only prescribe from the range of medication linked to their recorded qualification (SP or IP) and within their own level of experience and competence.

4.1.4      NMPs must ensure that patients are aware that they are being treated by a NMP and of the scope and limits of their prescribing, and that there may be circumstances where the patient may need to be referred to another healthcare professional to access other aspects of their care.

4.1.5      Clinical Management Plans (CMPs) MUST be in place and adhered to wherever supplementary prescribing is in operation. NMPs must be clear in what capacity they are prescribing and ensure appropriate records are kept.

4.1.6      All prescribing must conform to the SFT medicines policy as well as local and national prescribing guidelines (including the local formulary).

4.1.7      NMPs must have access to a current BNF and/or BNFc (as appropriate) when prescribing, BNFs are available in all clinics and wards and via ICID on the quick links

4.1.8      Adverse incidents must be reported via the Trust incident report forms as per SFT policy.

4.1.9      All suspected adverse drug reactions must be reported according to guidance from the MHRA/Commission on Human Medicines using the Yellow Card system.

4.1.10     It is the responsibility of all NMPs to maintain up-to-date knowledge and skills to enable prescribing to be undertaken competently and safely and to maintain a portfolio of their CPD as prescribers. As a professional recorded on the relevant professional register as being a prescriber, NMPs should ensure that their continuing professional development is in line with their role as a prescriber.

All NMPs have a professional responsibility to keep themselves up to date with clinical and professional developments within their professions. NMPs will be expected to keep themselves up-to-date with best practice in the management of conditions for which they can prescribe. All areas of NMP prescribing practice for SPs must be assessed and approved by the DMP.

4.1.11     Competency to prescribe must be checked annually as part of the performance review process.

4.1.12     All NMPs within SFT are encouraged to participate in NMP discussion fora either locally or via the internet to share good practice. A NMP forum operates within SFT and meets quarterly. Details are available from the Chief Pharmacist.

4.2 Process

4.2.1      All prescriptions must be written on SFT prescription forms, either inpatient drug charts, discharge summary/TTO forms or hospital outpatient prescriptions or, where available, via electronic prescribing systems. FP10HNC (formerly known as FP10HP) forms available within the Trust (for out of hours use only) may only be completed by dentists or doctors. There is currently no provision within the Trust for NMPs to prescribe items for supply through a community pharmacy. If there is a need for NMP to issue prescriptions for dispensing outside of the Trust this should be discussed with the Chief Pharmacist.

4.2.2      It is recommended that NMPs should not prescribe and then administer or dispense the prescription they have written. Where this cannot be avoided, a second suitably competent person should be involved in checking the accuracy of the medication provided.

4.2.3      Prescription charts/forms constitute controlled stationary and must be stored securely.

4.2.4      Medicines prescribed by NMPs (either as IP or SP) may be administered by other competent persons (so-called secondary administration).

4.2.5      Nurse and Pharmacist Independent Prescribers are authorised to prescribe all Controlled Drugs listed in Schedule 2-5 within their competence except cocaine, diamorphine and dipipanone for the treatment of addiction.

4.2.6      Unlicensed medicines are allowed to be prescribed by Independent Prescribers. Supplementary prescribers are allowed to prescribe an unlicensed medicine provided that it is part of the CMP and that there is no suitable alternative licensed product available. See also guidance from professional bodies and SFT Policy on use of unlicensed medicines.

4.2.7      IPs and SPs are allowed to prescribe medicines outside the terms of their licence (so-called â€˜off labelâ€™ prescribing) provided that it is in accordance with guidance from professional bodies and SFT Policy for â€˜off labelâ€™ prescribing.

4.2.8      NMPs can prescribe medications as part of clinical trials. The Pharmacy Dept MUST be provided with written confirmation of this arrangements signed by the local investigator and the sponsor for each relevant trial. This confirmation may be in the form of the site delegation log, a copy of which must be filed in the relevant pharmacy trial file. The prescriber must have undertaken GCP training within the last 3 years in accordance with Trust clinical trial standards. Where medication is prescribed as part of a clinical trial by a supplementary prescriber, a copy of the current CMP for each patients must be forwarded to pharmacy for the trial records.

4.2.9      Independent NMPs may in very exceptional circumstances only, issue a verbal instruction to administer a medicine or to vary the details of an existing prescription. The medication must be one within the NMPâ€™s area of competence and must not be a controlled drug. The situation must correspond to an emergency where the requirement to give a written authorisation would result in significant deterioration of the patientâ€™s condition. The NMP must adhere to the arrangements for remote orders as set out in the Trustâ€™s Medicines policy and must be able to justify their actions if called upon to do so.

4.2.10     Prescriptions must be written legibly and in ink, they must be dated, state the full name and address of the patient and be signed in ink by the prescriber. The prescriberâ€™s status must be clearly printed after their signature, i.e. IP or SP. Equivalent requirements pertain for electronic prescriptions.

4.2.11     Prescriptions must be checked against the Register of NMPs approved for practice with SFT before dispensing. SFT pharmacy will only dispense NMP prescriptions written by NMPs on the Register of NMPs approved for practice within SFT and whose signatures are held by the pharmacy department.

4.3 Record Keeping

4.3.1      NMPs must make records of all patient consultations directly in the patientâ€™s health care record[2] , when they are providing direct care, or prescribing medication within their approved remit. The outcome of the consultation must be communicated in an appropriate manner to the patientâ€™s GP and other relevant clinical colleagues. Copies of letters to GPs et al detailing the consultation may be used as the record within the patientâ€™s health care record.

4.3.2      Records must be written legibly, indelibly and be accurate, comprehensive, contemporaneous and accessible by all members of the prescribing team. Alterations must only be made by scoring out with a single line. The correct entry should then be initialled, dated and timed. Additions to existing entries must be individually dated, timed and signed. Refer to the â€œStandards for Record Keepingâ€ on the SFT intranet.

4.3.3      All professionally held records must be stored in a secure manner. All staff must follow the SFT Confidentiality Policy in relation to patient records.

4.3.4      Supplementary prescribers must have a copy of the patient specific Clinical Management Plans (CMP) in the patientâ€™s healthcare record. Patients should be given a copy of their consultation record where requested and in line with Trust policy.

4.4 Probity

4.4.1      NMPs may not prescribe within SFT for themselves, their colleagues, their family or their friends.

4.4.2      NMPs must ensure that there is no conflict of interest regarding dispensing of prescriptions.

4.4.3      All NMPs must abide by the Trust policy on Medical Representatives and Trust Standing Financial Instructions. Representatives from pharmaceutical companies must follow the Trust policy regarding appointments with prescribers. Sponsorship of any sort, including hospitality, meetings and conferences, should not compromise any prescribing or purchasing decisions. These must be based upon clinical evidence and what is in the best interests of patients. Value for money in the use of public money must remain a priority at all times.

4.5 Legal and Clinical Liability

4.5.1      Prescribers are accountable for all aspects of their prescribing decisions. NMPs are expected to only prescribe those medicines they know are safe and effective for the patient and the condition being treated. Staff must be able to recognise and deal with pressures (e.g. from the pharmaceutical industry, patients or colleagues) that might result in inappropriate prescribing.

4.5.2      Job descriptions for NMPs must clearly state that prescribing is required as part of the duties of the post. This must include in section 5, the requirement for the relevant qualification and registration as a prescriber with the appropriate regulatory body and, in section 6, a statement of responsibilities such as â€˜To contribute to safe and effective patient care through the application of prescribing competencies in relation to [specify patient cohort eg respiratory] patients in accordance with national guidelines, evidence based practice and local Trust policies.â€™

4.5.3      SFT will hold vicarious liability for NMPs where the following criteria are met:

* The NMP is appropriately trained and qualified and registered for this qualification with their professional body (i.e. NMC or GPhC)
* Approval has been given for the extended role by the Trust
* Prescribing is part of his/her professional duties and this is documented in the job description
* The NMP is on the Trust register on NMPs (see 3.5),
* The NMP works within the legal framework of the role, within the competence of the individual, within the CMPs (as appropriate) and within Trust policies.

In addition, NMPs are individually and professionally accountable to their professional body for this aspect of their practice, as for any other, and must act at all times in accordance with their Code of Professional Conduct and Scope of Professional Practice.

4.5.4      In addition, the NMC, GPhC, HCPC and DH recommend that all NMPs should have sufficient professional indemnity insurance through the NMPâ€™s professional organisation or through an independent insurer or trade union.

5. Formulary submissions

All new drug applications must be submitted according to the current DTC policy. NMPs may not submit new applications.

6. Ordering and receiving laboratory tests

All laboratory tests should be ordered and dealt with in accordance with the relevant policy.

7. Audit

Audit criteria are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
|   | **Criteria** | **Compliance Level** | **Exceptions** |
| 1 | NMP must to be on the Trust register of NMPs before commencing prescribing activities | 100% | NIL |
| 2 | NMP must be able to demonstrate ongoing competency within the NMP role | 100% | NIL |
| 3 | NMP must be able to demonstrate appropriate and ongoing CPD activities | 100% | NIL |
| 4 | NMP must have annual appraisal incorporating prescribing issues | 100% | NIL |
| 5 | NMP prescribing is consistent with their area of expertise and role as an independent or supplementary prescriber | 100% | NIL |
| 6 | NMP must record all prescribing errors via the Trust Incident Reporting Scheme | 100% | NIL |

8. References

1. â€˜Medicines Matters. A guide to mechanisms for the prescribing, supply and administration of medicines.â€™ DH July 2006
2. â€˜Improving Patientsâ€™ Access to Medicines: a guide to implementing nurse and pharmacist independent prescribing within the NHS in Englandâ€™. DH April 2006
3. â€˜Standards of proficiency for nurse and midwife prescribersâ€™ NMC, June 2012
4. Home Office Circular 009/2012
5. â€˜Standards for medicines managementâ€™, NMC, Sept 2012
6. â€˜Prescribing Rightsâ€™ PSNC, June 2013

1]Optometrist independent prescribers may prescribe any licensed medicine for ocular conditions affecting the eye, and the tissue surrounding the eye, within their recognised area of expertise and competence, except for controlled drugs or medicines for parenteral administration.

[2]Includes electronic prescribing records/systems

Review Date: 01/02/2019

### Non - Medical Prescribing policy and Clinical Governance Framework Appendices

#### Appendix 1 Mechanisms Through Which Supply and Administration of Medicines are Authorised within SFT

**MECHANISMS THROUGH WHICH SUPPLY AND ADMINISTRATION OF MEDICINES ARE AUTHORISED WITHIN SFT**

This paper sets out the means through which medicines may be supplied and/or administered within Salisbury NHS Foundation Trust.

**1       PRESCRIPTIONS AND PATIENT SPECIFIC DIRECTIONS**

Prescriptions and patient specific directions are written instruction from qualified and registered prescribers, for a medicine including the dose, route and frequency to be supplied and/or administered to a named patient.

**2       PATIENT GROUP DIRECTION (PGD)**

A Patient Group Direction (PGD) is a written instruction for the supply and/or administration of a licensed named medicine in an identified clinical situation, where the patient may or may not be individually identified before presenting for treatment.

The law stipulates the process by which PGDs must be drawn up and the approval process.  It is essential that anyone involved in the delivery of care within a PGD is aware of the legal requirements.   PGDs are NOT a form of prescribing.

**3       LOCALLY AGREED CLINICAL PROCEDURE (LACP)**

Locally  Agreed  Clinical  Procedures  are  used  within  SFT  in  certain tightly defined situations.  The rules on development and approval are the same for PGDs.

**4       MEDICINES  ACT  EXEMPTIONS  (MEDICINES  AUTHORISED  BY STATUTE FOR ADMINISTRATION BY SPECIFIED GROUPS OF HEALTHCARE PROFESSIONALS)**

Certain groups of healthcare professionals including midwives and paramedics have specific exemptions in medicines legislation to supply and/or administer medicines.   Provided the requirements of any conditions attaching to those exemptions are met no other authorisation is required

**5       POLICY    FOR     THE    ADMINISTRATION     OF     DISCRETIONARY MEDICINES BY REGISTERED NURSES AND MIDWIVES**

This policy permits the administration, without prior prescription, of certain specified General Sales List (GSL) and Pharmacy (P) medicines to adult patients (16 yrs and over) at the discretion of nurses and midwives   registered   with   the   NMC,   in   accordance   with   certain conditions.

**6       INDEPENDENT PRESCRIBING (IP)**

**Nurse independent prescribing** allows suitably trained and registered practitioners3  to prescribe any medicine, **licensed and unlicensed**, for any medical condition within their own level of professional competence and expertise. Nurse independent prescribers may also prescribe, administer, and give directions for the administration of Schedule 2, 3, 4 or 5 Controlled Drugs.  This extends to diamorphine, dipipanone or cocaine for  treating  organic  disease  or  injury,  but  not  for  treating addiction.

*Community Practitioner Nurse Prescribers* are a distinct group under independent prescribers. They consist of district nurses, health visitors and school nurses who are allowed to independently prescribe from a limited formulary called the Nursing Formulary for Community Practitioners which includes over-the-counter drugs, wound dressings and appliances.

**Pharmacist Independent Prescribing** allows suitably trained and registered pharmacists1 to prescribe any **licensed and unlicensed** medicine for any medical condition prescribe within their own level of professional competence and expertise. Pharmacist independent prescribers may also prescribe, administer, and give directions for the administration of Schedule 2, 3, 4 or 5 Controlled Drugs.  This extends to diamorphine, dipipanone or cocaine for treating organic disease or injury, but not for treating addiction.

**Optometrist Independent Prescribing** allows suitably trained and registered practitioners4 to prescribe any licensed medicine for ocular conditions affecting the eye and the tissue surrounding the eye, except for Controlled Drugs or medicines for parenteral administration. Optometrist Independent Prescribers must work within their own level of professional competence and expertise.

3 IP role must be stated in the individualâ€™s job description and their name must appear on the

Trust register of NMPs maintained on behalf of the Trust by the Chief Pharmacist.

4 IP and SP roles must be stated in the individualâ€™s job description and their name must

appear on the Trust register of NMPs maintained on behalf of the Trust by the Chief

Pharmacist

**7       SUPPLEMENTARY PRESCRIBING (SP)**

Supplementary prescribing is a voluntary prescribing partnership between an independent prescriber (doctor or dentist) and the supplementary prescriber, to implement an agreed patient-specific clinical management plan (CMP) with the patientâ€™s agreement.  SPs can prescribe **Controlled Drugs** and **unlicensed medicines** in partnership with a doctor, where the doctor agrees within a patientâ€™s CMP.  Nurses, midwives, pharmacists, physiotherapists, chiropodists/podiatrists, radiographers and optometrists may qualify and register as SPs2.

**8       REMOTE ORDERS**

Only in **very exceptional** circumstances may a nurse or midwife act on a verbal instruction from a prescriber to administer a medicine or to vary the details of an existing prescription.  The situation must correspond to an emergency where the requirement to give a written authorisation would result in significant deterioration of the patientâ€™s condition.

Controlled Drugs may NOT be administered on a remote order.

**9       FURTHER INFORMATION**

A schematic representation of the mechanisms for supply and administration of medicines within SFT is attached.

Staff wanting to know more about any of these mechanisms and how they might benefit clinical practice are welcome to contact Sally Tomlin, Chief Pharmacist or Peter Davies, Snr Pharmacist.

**10      REFERENCES**

Medicines Matters, A guide to mechanisms for the prescribing, supply and administration of medicines. DH, July 2006

Prescribing rights, PSNC, June 2013

Standards for Medicines Management, NMC, Sept 2012

Written by Sally Tomlin, Chief Pharmacist on behalf of the Increasing Access to Medicines Panel. Oct 06

Approved by DTC January 2007

Review date January 2009

Revised June 2009 and July 2013

Review date July 2015

Reviewed and updated Feb 15. Next review due Feb 2018

#### Appendix 2 Application to Train as an NMP

http://mg.salisbury.nhs.uk/media/1771/application-to-train-as-an-nmp.pdf

#### Appendix 3 Process for Approval to Develop NMP Services and Train as an NMP

http://mg.salisbury.nhs.uk/media/1772/process-for-approval-to-develop-nmp-services-and-train-as-an-nmp.pdf

#### Appendix 4 Application to be Included on the Trust Register of NMP Once Qualified

http://mg.salisbury.nhs.uk/media/1770/application-to-be-included-on-the-trust-register-of-nmp-once-qualified.pdf

#### Appendix 5 Process for Approval to Practicea as an NMP Within SFT

http://mg.salisbury.nhs.uk/media/1773/process-for-approval-to-practicea-as-an-nmp-within-sft.pdf

#### Appendix 6 Template CMP 1

http://mg.salisbury.nhs.uk/media/1774/template-cmp-1.pdf

## NSAID Interactions

**Drug Interaction Examples - NSAIDS (Including COX 2 Selectives)**

This is not a comprehensive list please refer to the current BNF for a full list of drug interactions

| **Drug Class** | **Clinical Importance** | **Monitoring** | **Mechanism** |
| --- | --- | --- | --- |
| **Cardiovascular drugs** |
| a) Cardiac Glycoside | NSAIDs may increase plasma concentration of digoxin and NSAIDs can exacerbate heart failure and impair renal function. | Monitor digoxin plasma level if concerned about possible toxicity. Monitor heart rate and adjust the digoxin dose accordingly. | NSAIDs can cause deterioration in renal function, which could result in digoxin toxicity |
| b) Diuretics | Increased risk of NSAID induced nephrotoxicity and antagonism of diuretic effectPatients with cirrhosis, cardiac failure, renal impairment or advanced age are most at risk. Possibility of increased risk of hyperkalaemia when given with potassium sparing diuretics and aldosterone antagonists. | Monitor renal function andelectrolytes. Adjust diuretic dose as necessary | NSAIDs block the renal synthesis of prostaglandins, which will affect renal blood flow and diuresis. |
| c) Beta-blockers | Evidence suggests that somepatients treated with beta- blockers who are administered NSAIDS  can show a rise in blood pressure. It may not be clinically relevant. The effects may be greater in the elderly and those patients whose blood pressure is relatively high. | Monitor the BP. Anticipate the need toincrease the beta-blocker dose. | NSAIDs  can raise the BP.   NSAIDs  inhibit the synthesis and release of prostaglandins which have a potent dilating effect. Therefore the blood pressure rises. Resulting in the hypotensive actions of the B-blockers being opposed by the hypertensive actions of NSAIDs. |
| d) Vasodilatorantihypertensive drugs | Antagonism of hypotensive effect. | Monitor blood pressure |   |
| e) Drugs affecting therenin-angiotensin system. ACE inhibitors and Angiotensin â€“ II receptor antagonists | Increased risk of hyperkalemia and renal impairment. Also hypotensive effect antagonised when NSAIDs and ACE inhibitor/ Angiotensin-II receptor antagonist co- administered. | Monitor renal function, serum potassium and BP. Reduce NSAID dose or increase ACE inhibitor/ Angiotensin-II receptor antagonist dose. | The inhibiting of prostaglandin synthesis may partially antagonize the effect of ACE inhibitors. A non-specific mechanism such as sodium retention maybe involved. |
| f) Pentoxifylline | Possible increased risk of bleeding with concomitant use | Avoid concomitant use |   |
| g) Anticoagulants,Aspirin and clopidogrel | All NSAIDs can cause some gastrointestinal irritation and possible bleeding and concomitant use should be avoided if possible. | Avoid concomitant use if possible due to increased risk of GI bleed. | NSAIDs irritate the stomach lining and have effects on platelet activity which can affect bleeding times and result in gastrointestinal bleeding and ulceration. |
| **Central Nervous system** |

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| --- | --- | --- | --- |
| Antidepressants | Increased risk of bleeding when NSAID given with SSRIs or Venlafaxine. | Avoid concomitant use if possible, but if it is unavoidable then add a gastroprotective drug. Especially in the elderly and those and risk of GI bleeding. |   |
| Lithium | A marked unpredictable and rapid increase in lithium levels may occur | Avoid concomitant use | Reduced renal excretion of lithium |
| Phenytoin | Concomitant use  of a NSAIDs can increase phenytoin levels. Only significantly increased by NSAIDs with high proteinbinding e.g azapropazone | Monitor phenytoin levels if concerned about possible toxicity | Inhibition of liver enzyme Protein binding displacement of phenytoin |
| **Infections** |
| Quinolones | Possible increased risk of convulsions when quinolones given with NSAIDs | Monitor patients for increase in number of convulsions | It is not fully understood. Convulsions have occurred in patients taking quinolones alone, the NSAID may lower the amount of quinolone required to precipitate convulsions in susceptible individuals |
| **Endocrine System** |
| Sulphonylureas | NSAIDs may enhance effects of sulphonylureas. | Blood glucose monitoring. | A reduction in the renal clearance of antidiabetic drugs can result in hypoglycaemia. |
| **Obstetrics, gynaecology and urinary tract disorders** |
| Mifepristone |   | Avoid concomitant useUse alternative analgesia | The manufacturers of mifepristone say that the antiprostaglandin effects of NSAIDs including aspirin could theoretically decrease the efficacy of mifepristone. |
| **Malignant disease and immunosuppression** |
| Methotrexate | Unpredictable, serious interaction resulting in increased risk of methotrexate toxicity. | NSAIDs and methotrexate should only be co-prescribed and carefully monitored by the Rheumatology team. | NSAIDs inhibit the synthesis of the prostaglandins, resulting in decreased renal perfusion and reduced methotrexate elimination.The development of toxicity may be dose related and the risk appears to be lowest in those taking low-dose methotrexate for psoriasis or rheumatoid arthritis who have normal renal function. |
| Tacrolimus | Increased risk ofnephrotoxicity | Advisable to avoid concomitant use | Inhibition of vasodilatory prostaglandins |
| **Musculoskeletal and joint disease** |
| Probenecid | Be alert for any evidence of increased NSAID side effects and reduce the NSAID dose | In general no special precautions, reduce the NSAID dose if necessary | Probenecid possibly inhibits the liver metabolism of NSAIDs |
| Baclofen | Increased risk of baclofen toxicity | Reduce the baclofen dosage as necessary | Reduced excretion of baclofen |

**NB: This list is not comprehensive and non inclusion of a drug does not indicate a lack of any clinically significant drug interaction**

**Document Owner:** Peter Davies

## Patient Group Direction Template

Patient Group Direction Template

http://mg.salisbury.nhs.uk/media/1072/pgd-template.doc

**Document Owner:** Steve Bleakley