



INDEPENDENT NON-MEDICAL PRESCRIBING (NMPs) POLICY

Version:	1.0
Policy owner:	Clinical Governance Lead
Ratified by:	Chief Executive
Date approved:	28 th November 2014
Approved by:	Suffolk GP Federation Board
Review date:	1 st March 2016
Target audience	All staff



INDEPENDENT NON-MEDICAL PRESCRIBING (NMPs) POLICY

This paper sets-out the protocol to be followed for all non-medical prescribers working in the Home Care and Diabetic Management Services.

Training

All non-medical prescribers must have completed the level 6/7 non-medical prescribing course prior to registering with their professional bodies. A copy of the certificate to be kept on the prescribers HR file and reviewed annually.

The NMP must ensure that they attend an appropriate refresher prescribing course every two years and on-going training updates relevant to practice as required.

During the annual appraisal will need to demonstrate the ability to continue to prescribe efficiently and safely.

Responsibilities

NMPs have three responsibilities

- Each non-medical prescriber must recognise his/her own limitations and refer to an appropriate medical prescriber for assessment of prescribing outside their level of practice or expertise.
- All NMP are required to record details of the patients consultation together with details of the NMP's prescription in the patient's case notes as soon as possible (NMC 1998)
- All NMP have a duty to notify the Medicines and Health Care Products Regulatory Agency, via the ADR Reporting Scheme, if an adverse reaction occurs using the yellow card scheme or via www.yellowcard.gov.uk .

Audit

Suffolk GP Federation CIC recognises its responsibility to check practice in adherence to all policies. A 1% audit will be undertaken quarterly relating to non-medical prescribing.

Every practice that has had registered patients seen and assessed by a Federation Nurse in a care home, home visit or clinic will be asked to provide information for the Lead Nurses to audit individual practitioners practice. (Use Federation audit tool sheet **Appendix One**)

This audit will include:

- Prescriptions must be written clearly, use approved/brand drug name and have clear instructions of dose, route, form and strength.
- Prescriptions must include patients name, address, DOB, GP practice code.
- All prescriptions must include the non-medical prescriber's identification number(PIN printed on FP10)

Non-Medical Prescribing Protocol

1 – Issuing Prescriptions

ACTION	RATIONALE SAFE PRESCRIBING PRACTICE
<p>1 a) If a prescription is hand written the NMP should complete all the details on the FP10 prescription form which bears their own name and NMC PIN number by writing clearly and legibly using a black pen. b) The patients surname, first name DOB, age and full address must be included. c) The name of the product – approved generic titles should be used wherever possible, form and strength (if any) , topical application (indicate area) of the prescribed item, dosage, frequency d) The completed FP10 should be signed and dated.</p>	<p>To ensure correct prescribing practice.</p>
<p>2 All computer generated prescriptions must be signed-authorisation to prescribe via the GP computer system should be via the Lead ANP</p>	<p>To ensure all prescribers are recorded and monitored</p>
<p>3 Following a full assessment of patient, this assessment must be recorded in the appropriate documentation or on the GP computer system</p>	<p>Prescribing is documented as part of the care/ treatment plan</p>
<p>4 No more than four weeks supply of any product should be prescribed at any one time.</p>	<p>To ensure compliance and review of patient</p>
<p>5 Repeat prescriptions can only be issued to enable an ongoing plan of care. Any repeat prescribing request must be reassessed by the NMP who will reassess the need and act accordingly, recording his/her action within the patients and GP notes as appropriate</p>	<p>To ensure quality of care</p>
<p>6 Prescriptions for no longer than 12 months should be provided</p>	<p>To comply with good practice</p>
<p>7 NMPs must not prescribe for themselves or a family member or anyone whom they have a close personal or emotional relationship</p>	<p>To comply with professional standards</p>
<p>8 The prescriber should ensure that a contact number is recorded clearly on the prescription</p>	<p>To enable patient/ pharmacist to contact prescriber</p>
<p>9 The NMP should ensure that the GP practice code is recorded on the prescription. Care will need to be taken to ensure the correct code is</p>	<p>To allow accurate prescribing budget allocation</p>

recorded.	
10 If a patient reports a severe or unexpected reaction to a prescribed medicine it should be reported to the MHRA using the Yellow Card System. It should also be reported to the GP and all adverse reactions and actions taken should be documented in the patients notes	To minimise any reactions and ensure patient is not prescribed drug again. To allow others to learn.

2- Record keeping/Communication

ACTION	Rationale Safe Prescribing Practice
1 All staff are required to keep accurate, comprehensive and accessible records, which are unambiguous and legible. Details of the assessment, prescription, rationale for prescribing and review, must be entered in the patient notes. NMP should also if needed inform the patients on how to take the medicine and the importance of compliance	To ensure compliance with Professional standards
2 An NMP consultation form must be completed for those NMP's who have no access to GP patient records. This should be faxed/ forwarded to the GP within 48 hours (or immediate contact with GP if deemed necessary) . The patient consultation should be entered into the GP system ASAP	To ensure information is shared and prescribing errors/duplication avoided.

3 - Security and safe handling of prescriptions

ACTION	Rationale Safe Prescribing Practice
1 The Lead ANP keeps a record of all Suffolk GP Federation NMP FP10 prescription pads issued and prescribers must sign for receipt of them. Practice specific pads can be ordered by the practice (once set up by the ANP Lead). It is the responsibility of the NMP to ensure security of their prescription pads at all times	To ensure that staff comply with safe and secure handling of prescription pads as set down by professional bodies and prevent fraudulent use of prescriptions
2 The prescription pad must only be produced when needed and never left unattended or left in the prescriber's car. When not in use the prescription pad must be stored in a locked cupboard or drawer	
3 Under no circumstances should blank prescriptions forms be pre-signed before use	
4 Prescription pads must be left intact until a	

prescription is issued. A record of the last prescription written should be made in order to know all prescription numbers that are remaining on the pad- in case a pad is lost or stolen	
5 NMPs must only issue prescriptions bearing their own name and NMC number	
6 If a prescription is written in error VOID should be written across the prescription, a note of the prescription number and reason for destruction should be made. The void prescription form should be shredded ASAP	Safety and security of prescription forms and patient details
7 The prescription pad must be returned to the ANP Lead before the last day of employment. Any un-used prescription forms will be recorded and shredded by the ANP Lead. Prescription pads should not be sent by mail but must be returned in person to the ANP Lead The prescriber should be removed from any electronic prescribing system .	Safety and security of prescriptions forms. Ensure current forms are in use
8 Before commencement of maternity leave or anticipated long term sickness prescription pads should be returned to the ANP Lead- Prescription forms can become out of date	

4 - Stolen/ Lost FP10 Prescription Forms

ACTION	Rationale Safe Prescribing Practice
1 The NMP will inform Lead ANP, as soon as they become aware that any of their prescriptions have become lost or stolen.	Lost or stolen prescription pads will be reported within 2 hours of the loss being identified
2 The Lead ANP/ Manager will: <ul style="list-style-type: none"> a) Report the loss immediately to the Suffolk Fed Medical Director and Operations Director Contact b) Notify the loss to the police and obtain a crime number c) Contact NHS Suffolk/Essex who will ask for a crime number and inform pharmacist of the loss 	To ensure that the police and pharmacist are aware
3 The NMP must refrain from issuing prescriptions until otherwise informed to do so and should write prescriptions in red ink for a period of two months	To prevent fraudulent use of prescriptions
4 A Suffolk Fed incident form must be completed within 1 day	To monitor incidents of this

5- Requesting and Receiving Prescription pads

ACTION	Rationale Safe Prescribing Practice
1 The Lead ANP Home Care Suffolk and Admin . Support for North East Essex will authorise the ordering of personalised prescription pads	Personalised prescription pads will only be issued to registered non- medical prescribers
2 Replacement pads can take up to 3 weeks to arrive, this should be taken into account when re-ordering	To ensure continuity of supplies
3 Prescription pads will be collected from Riverside clinic. Suffolk and designated safe location for Essex The prescriber must sign for receipt of the pads	To ensure safe practice
4 If there is a need, a stock pad (one for each nurse) can be held in a lockable cupboard/ drawer. The prescriber should request a new prescription pad once the stock pad is in use	To prevent loss or theft, ensure continuity in prescribing.

The role of the Non NMP Diabetes Specialist Nurse (DSN) in changing an insulin regime of patients where the Registered district Nurse has to administer the insulin.

A patient is identified by the community nurses as unstable, they will:

- Contact GP for advice and follow advice or
- Gain permission from GP to refer to Diabetic Specialist team for advice.

The patient will be reviewed by the DSN.

If identified as requiring a dose change or a new insulin regime, the DSN Non NMP can:

- **Recommend** the change of dose insulin
- **Recommend** a new insulin regime and doses required

The DSN Non NMP will:

- Detail in the patients notes the recommendation.
- Contact the GP / or prescriber by phone for GP / prescriber to initiate the prescription or
- Contact the GP / prescriber by phone to ask GP / prescriber to generate the authorisation form to stipulate the variance in the dose.
- Inform the referring District Nurse by phone * of the recommendation.
- Complete and share record with DN team
- GP / Prescriber will fax the authorisation form to the DN base
- DN will take to patient's home.

A DSN NMP will:

- Detail in the patients notes the recommendation
- Generate a prescription (if new insulin)
- Complete the authorisation form on SystemOne
- Fax the form to the DN base (form will have electronic signature as per NMC Guidance 2010)

Additional Notes

If the authorisation form is not generated by SystemOne, a copy of the authorisation form will be scanned on to the patients SystemOne template.

All patients will have their records shared between the services.

Prescribed Variable Doses

Some patients require insulin according to carbohydrate counting or due to unstable glucose levels. In these situations Federation employees will follow the standard set by NMC 2010.

NMC (2010) Standard 13 : Titration

Where medication has been prescribed within a range of dosages it is acceptable for registrants to titrate dosages according to patient response and symptom control, and to administer within the prescribed range.

NMC (2010) Guidance

A registration must be competent to interpret test results, for example blood results(glucose levels (insulin)), and assess the patient.

Suffolk GP Federation recommend that only Diabetic Specialist Nurses working at Level 4 of the Diabetic Competency Framework will advise on the titration of insulin and follow procedures set out in this document for the completion of the Authorisation for administration of medicines in the community (AAMC) . The District Nurse will then follow the instructions as set within the AAMC.

*If not on duty to contact the office to ask for the patients nurse to contact the DSN

Reporting

All referrals will be acknowledged according to the organisations procedures.

All activity performed by the DSN will be recorded within SystemOne within two working days.

A letter will be sent to the registered GP detailing any changes in treatment or care.



The patients' record on SystemOne will be shared with all other involved health professionals and notification sent to advise them of any changes, it will remain their responsibility to access the data and follow any changes in the patients plan. This includes any changes in treatment and completion of medication change forms will be held on SystemOne.

Appendix One

1% Audit Template

- Auditor must audit the record with the information available at the time of the contact with the patient (do not include any information found on further contact with the patient).
- If the answer to the question is “in part” then the reasons for this MUST be documented
- There must be evidence in the patient record that all standards were checked e.g. allergies – either details of allergy or recorded as no allergy in order to ascertain that the question has been asked of the patient
- Yes = 2 points, In Part = 1 point and No = 0 points
- Total possible score = 32 (with no exclusions – n/a)
- Any problems identified regarding the Clinical competency of a Clinician must be addressed immediately by line manager in the most appropriate way
- Score of < 90% – letter to Clinician to address record keeping issues (after 3 letters it is advisable for the line manager to meet with Clinician)
- All Clinicians to receive a report every six months

No	Standard	Yes (2)	In part (1)	No (0)	N/A ✓
1	Appropriate History Taking				
a	Identifies main reason for contact +/- patient’s concerns				
b	Clearly records history of presenting complaint				
c	Records appropriate information e.g. red flags +/- significant negatives				
d	Clearly records past medical history				
e	Clearly records any social issues e.g. carer, housing etc				
f	Clearly records current and regular medication (inc OTC meds)				
g	Clearly records/read-codes allergies (or no known allergies)				
2	Carries out appropriate examination of mental and physical Health				
a	Records appropriate physical (and/or mental state) examination				
b	Records all appropriate examination findings including significant negatives and observations (BP, RR, temp etc)				
3	Draws Appropriate Conclusions				
a	Makes and records appropriate diagnosis (including differential diagnoses where appropriate)				
b	Gives appropriate lifestyle advice where applicable				