Report of the Advisory Group on Nurse Prescribing.

REPORT OF THE ADVISORY GROUP ON NURSE PRESCRIBING

DEPARTMENT OF HEALTH

DECEMBER 1989

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APPENDICES PAGE

TERMS OF REFERENCE

1. To advise the Secretary of State, after consultation with the Standing Medical Advisory Committee, the Standing Nursing and Midwifery Advisory Committee and the Standing Pharmaceutical Advisory Committee, how arrangements for the supply of drugs, dressings, appliances and chemical reagents to patients as part of their nursing care in the community might be improved by enabling such items to be prescribed by a nurse, taking into account where necessary current practice and likely developments in other areas of nursing practice.

2. To make recommendations on:

i. the circumstances in which nurses might prescribe, order or supply drugs, dressings, appliances and chemical reagents, taking account of such professional and ethical issues as responsibility, accountability and inter-professional communication;

ii. the categories of items which might properly be prescribed, ordered or supplied by nurses and the arrangements which would be needed for drawing up and maintaining a list of such items;

iii. the methods by which drugs, dressings, appliances and chemical reagents might be prescribed, ordered or supplied by nurses, having regard to current guidance on the safe and secure handling of medicines.

3. To make recommendations on the circumstances in which a nurse might properly vary the timing and dosage of drugs prescribed by a doctor.

4. To advise on the implications of these recommendations for nurse training.

5. To consider the resource implications of the recommendations.

6. To report by 1 October 1989.

SUMMARY

This report recommends that certain groups of nurses working in the community should be authorised to prescribe from a limited list of products and to supply medicines, or vary their timing and dosage, within agreed protocols. It puts forward proposals for the introduction of nurse prescribing and suggests a timetable for the necessary education and training of nurses and for the legislative changes that will be required.

The recommendations are addressed to the Department of Health, to the professions, to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), and to Health Authorities.

I. The core recommendations are:

Recommendation 1 (Chapter 1, paragraph 1.22)

Suitably qualified nurses working in the community (as defined below) 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.

Recommendation 2 (Chapter 2, paragraph 2.3)

Certain specified groups of nurses should be able to:

- prescribe from a Nurses' Formulary (initial prescribing);

- supply within a group protocol agreed for a particular clinical service. The protocol should include arrangements for initial assessment and review;

- adjust the timing and dosage of medicines within a patient-specific protocol.

Recommendation 3 (Chapter 3)

Nurses with a district nurse or health visitor qualification (including those employed as paediatric community nurses, practice nurses or private nurses - paragraph 3.5), having had the necessary additional training:

i. should be empowered to prescribe items necessary for the care of patients with those conditions for which the nurse takes independent clinical responsibility (paragraph 3.4);

ii. should be able to supply certain categories of patients with items within a group protocol and adjust the timing and dosage of medicines within a patient-specific protocol (paragraphs 3.10-3.12).

Recommendation 4 (Chapter 3, paragraph 3.10)

Supply within a group protocol. In addition to nurses with a district nurse or health visitor qualification, certain groups of nurses who have successfully completed the appropriate specialist education, training and assessment should be able to supply certain categories of patients with items within a group protocol. At present, we recommend that stoma care nurses, continence advisers, school nurses and paediatric clinical nurse specialists should be given this authority.

Recommendation 5 (Chapter 3, paragraph 3.12)

Adjusting timing and dosage of medicines. In addition to nurses with a district nurse or health visitor qualification, certain community nursing staff who have successfully completed appropriate specialist education, training and assessment should be able within a patient-specific protocol to adjust the timing and dosage of medicines which are prescribed by medical practitioners. At present we propose that community psychiatric nurses, community mental handicap nurses, specialist nurses for terminally ill patients and diabetic liaison nurses should be given this authority.

Recommendation 30 (Chapter 10, paragraphs 10.2-10.4)

An appropriate timetable for the introduction of nurse prescribing should be set nationally in consultation with potential nurse prescribers and taking account of education and training requirements. The legislative and education/training timetables should be co-ordinated. The aim should be to introduce nurse prescribing on 1 April 1992.

II. The following recommendations are addressed to the Department of Health:

Recommendation 9 (Chapter 4, paragraph 4.10)

A Nurses' Formulary should be drawn up by the Department of Health, in consultation with the appropriate professions, to include the groups of medicines, dressings and appliances, and diagnostic agents set out in Appendix E.

Recommendation 29 (Chapter 8, paragraph 8.6)

The necessary legislative changes should be made as soon as possible in order to enable nurses with district nurse and health visitor qualifications to prescribe all the items in the Nurses' Formulary.

Recommendation 10 (Chapter 4, paragraph 4.11)

The Nurses' Formulary should be reviewed regularly, taking account of appropriate professional advice.

Recommendation 25 (Chapter 7, paragraph 7.15)

Prescription pads printed on distinctive paper should be issued to authorised nurse prescribers working in the NHS and include the name, qualifications, professional address and telephone number of the prescriber.

Recommendation 26 (Chapter 7, paragraph 7.16)

Prescriptions issued by nurses working outside the NHS should carry the name, qualifications, professional address and telephone number of the prescriber.

Recommendation 31 (Chapter 10, paragraph 10.8)

An evaluation programme should be establised before the implementation of nurse prescribing so that some relevant baseline information can be gathered.

Recommendation 32 (Chapter 10, paragraph 10.8)

The evaluation study should include an assessment of the views of patients, relatives, nurses and other members of primary health care teams, as well as a full economic appraisal. Where possible, health outcomes should be measured.

Recommendation 6 (Chapter 3, paragraph 3.9)

Further consideration should be given, in the light of experience, to extending initial prescribing authority to some other groups of specialist nurses.

Recommendation 7 (Chapter 3, paragraph 3.16)

The groups of specialist nurses identified in recommendations 4 and 5 as authorised to supply items, or adjust the timing and dosage of medicines, should be reviewed from time to time to take account of changes in clinical practice, and the role of family planning nurses should be considered in this context.

III. The following recommendations are addressed to the professions:

Recommendation 14 (Chapter 6, paragraphs 6.1 and 6.5)

Good communications between health professionals and patients, and between different professionals, are essential for high quality health care. All health professionals empowered to prescribe for a patient should have access to the relevant patient records.

Recommendation 19 (Chapter 6, paragraphs 6.12 and 6.13)

Patients' personal record cards showing the timing and dosage of all medication, and other relevant information, should be completed by each professional who prescribes for the patients and updated to show any changes. They should be available to doctors and nurses treating the patient and to pharmacists issuing medicines. Patient-held records of medication should be used wherever possible.

Recommendation 16 (Chapter 6, paragraph 6.10)

"Patient-specific protocols" should be drawn up by all the practitioners responsible for the care of the patient. These protocols must be written, with copies in the patient's records and available to all authorised prescribers for the patient and to pharmacists, as necessary.

Recommendation 17 (Chapter 6, paragraph 6.11)

In the event of a disagreement between professionals over the treatment of a patient, the general practitioner (GP) responsible for the care of the patient will, as at present, take the final decision.

Recommendation 18 (Chapter 6, paragraph 6.11)

The pharmacist must retain the right not to dispense a prescription on professional grounds.

Recommendation 8 (Chapter 3, paragraph 3.17)

A nurse who accepts a post for which the ability to prescribe, supply or adjust the timing and dosage of medicines is a requirement set out in the job description will be expected to accept this responsibility.

Recommendation 22 (Chapter 7, paragraph 7.6)

It should be the responsibility of each nurse to ensure that her qualifications are registered or recorded with the UKCC. The employing authority, and others involved in agreeing protocols, must make sure that she has done so.

IV. The following recommendations are addressed to the UKCC and National Boards for Nursing, Midwifery and Health Visiting:

Recommendation 11 (Chapter 5, paragraph 5.5)

The UKCC should be invited to devise a policy aimed at ensuring that all nurses currently holding district nurse and health visitor qualifications receive such additional education, training and assessment as will enable them to demonstrate to a National Board for Nursing, Midwifery and Health Visiting adequate knowledge of pharmacology and therapeutics relevant to the products which they may subsequently be authorised to prescribe.

Recommendation 12 (Chapter 5, paragraphs 5.6 and 5.9)

In future, all post-registration courses in health visiting and district nursing should include tuition and assessment to a level to be determined by the National Boards in pharmacology, therapeutics and practical prescribing. The present courses for continence advisers and specialist diabetic liaison nurses should be extended to include these subjects.

Recommendation 13 (Chapter 5, paragraph 5.10)

The UKCC and National Boards should be responsible for all aspects of policy in relation to nurse education and training, and for the provision of formal courses. No events wholly arranged or resourced by commercial companies should be recognised for formal training purposes.

Recommendation 20 (Chapter 7, paragraphs 7.3 and 7.4)

The UKCC should be asked to continue to identify nurses with district nurse and health visitor qualifications on its register, and to indicate which of those nurses have completed the necessary additional education and training to enable them to prescribe.

Recommendation 21 (Chapter 7, paragraph 7.6)

The UKCC should make the information on its register of nurse prescribers available to bona fide enquirers.

V. The following recommendations are addressed to Health Authorities and Family Practitioner Committees (FPCs):

Recommendation 28 (Chapter 7, paragraph 7.11)

Each authorised nurse prescriber working in the NHS should have an honorary contract with the appropriate FPC.

Recommendation 15 (Chapter 6, paragraph 6.10)

In every Health Authority, a group protocol agreed for a particular clinical service should be drawn up by those responsible for service delivery, using a working group which includes representatives of the doctors, nurses and pharmacists involved. The protocols must be written, regularly reviewed and issued to all relevant health professionals.

Recommendation 23 (Chapter 7, paragraph 7.6)

The employing authority should maintain records of authorised nurse prescribers in its employment.

Recommendation 24 (Chapter 7, paragraph 7.14)

Nurse prescribers should be provided with regular reports on their prescribing patterns.

Recommendation 27 (Chapter 7, paragraph 7.18)

Health Authorities should set up practicable systems in their own areas for the supply of single doses of some products, where appropriate, and to provide nurses with their necessary basic supplies.

CHAPTER 1
INTRODUCTION

Background

1.1 Nurses in the community take a central role in caring for patients in their own homes. Nurses 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.

1.2 In April 1986 the Government published "Neighbourhood Nursing - A Focus for Care"(1), the report of a review of community nursing services in England chaired by Mrs Julia Cumberlege. Among other recommendations intended to make better use of community nursing skills, the report concluded that:

"The DHSS should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme, and issue guidelines to enable nurses to control drug dosage in well-defined circumstances."

1.3 Behind this recommendation lay the Review Team's conclusions that

(a) district nurses' time was being wasted by their having to return to the surgery to ask doctors to write prescriptions for some of the basic items needed in day-to-day home nursing, and

(b) there was a strong case for enabling skilled nurses working in the community with terminally ill patients to use their professional judgement on such matters as the timing and dosage of pain-relieving drugs.

1.4 In 1987, "Nursing in the Community - a Team Approach for Wales" was published(2). This was the report of a team set up in Wales to review community nursing services, under the chairmanship of Mrs Noreen Edwards.

This review also recommended that nurses should be allowed to prescribe from a limited formulary.

1.5 The Government indicated its support for the Cumberlege Review Team's recommendation in a Health Circular, "Community Nursing Services and Primary Health Care Teams" (3), issued in November 1987. The White Paper "Promoting Better Health: The Government's Programme for Improving Primary Health Care" (4), published at the same time, announced the Government's intention to consult the Standing Medical, Nursing and Midwifery, and Pharmaceutical Advisory Committees about the professional and ethical implications of prescribing by nurses with a view to producing guidance. Those Committees agreed to nominate members to a joint working group, and the Advisory Group on Nurse Prescribing was set up to advise the Secretary of State on how nursing care in the community might be improved by enabling some nurses to prescribe certain items, and to suggest which categories of items might properly be prescribed, ordered or supplied by nurses, and in what circumstances. The group was also asked to make recommendations on the circumstances in which a nurse might vary the timing and dosage of drugs (Terms of reference, page 3). The definitions of "prescribe", "order" and "supply" which we have used are set out in the glossary at Appendix B.

1.6 The membership of the advisory group is set out in Appendix A. The group is extremely grateful to the many individuals and organisations (listed at Appendix C) who presented written and oral evidence and offered formal and informal comments on issues related to nurse prescribing. We thought it important to ensure that our work was based on a thorough and up-to-date understanding of what currently happens in the community. Our professional secretariat made a number of fact-finding visits to community nursing staff, managers and educationalists. Their views and the information they provided have been of great assistance in our subsequent work.

1.7 We have been impressed by the widespread support which exists for the basic concept of nurse prescribing, as shown by the response to the Cumberlege Report and by the views which have reached us subsequently from a number of sources. We appreciate, however, that nurse prescribing raises some complex professional, legal and economic questions which we have thought it right to acknowledge as they arise. We have sought to resolve those that fall squarely within our remit and to make clear that responsibility for others must lie elsewhere.

1.8 We are aware that special arrangements for prescribing currently apply to midwives and occupational health nurses working in the community. We would not wish to disrupt their practice, which is well-established and already clearly defined. It is not our intention that their position should be affected by the recommendations which follow.

1.9 Throughout the report we have referred to health professionals and patients as male or female, as seemed most natural. References are, of course, meant to cover both sexes.

Patients and nurses in the community

1.10 The advisory group was asked to focus its attention on the arrangements for prescribing for patients in the community, by which we mean people receiving care in their own homes or in some form of residential accommodation outside hospital. We recognise that our recommendations will have implications for nurses who work at least part of the time in hospital settings. We consider, however, that the emphasis must be on where patients receive nursing care rather than on where the nurses giving it are based. We have taken the view that recommendations founded only on a "traditional" view of community nursing staff would be of limited value and would fail to fit into the more integrated patterns of care which we hope and expect to see develop in the future.

1.11 Throughout our work, we have taken as our guiding principle the consideration of what is best for patient care, both in terms of clinical effectiveness and convenience for patients and their carers. We have not lost sight of the fact that effectiveness and convenience also matter to health professionals but, like professional boundaries, we have seen them as rather less important issues.

1.12 The delivery of good community-based care has become increasingly important as more people are cared for outside hospital for longer periods. Many factors have contributed to this trend. Patients themselves, by and large, would rather be looked after at home than in hospital. Improvements in the education and training of general practitioners (GPs) and better arrangements for direct access to diagnostic services have reduced the need for some hospital consultations and admissions. More and more treatment is being provided through day and short-stay care for which the primary care team

provides back-up. Thresholds for both admission to and discharge from hospital have changed, with many more dependent patients being cared for at home than has previously been the case. More effective drugs and support techniques for terminally ill patients, developed by staff working in the hospice movement, have also become available to community staff, giving many of them the skill and confidence to care for terminally ill patients at home.

1.13 At the same time, major developments are taking place in nursing and nurse education. Clinical nurse specialists have developed in areas such as paediatric nursing, diabetic care, stoma care and continence advice and they often provide services both in hospital and in the community. Community psychiatric nurses (CPNs) often develop special clinical skills and may work in many settings.

1.14 Major proposals for the reform of nursing, midwifery and health visiting education are contained in "Project 2000: A New Preparation for Practice" (5), which was published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1986. Its central thrust is towards better patient care, based on the health needs of the individual in all settings. The advisory group supports the general aims of Project 2000. We were also impressed by the nature, standard and content of the new pre-registration nurse programme outlined by the UKCC in its consultation document. As Project 2000 nurses emerge it may be necessary to modify education for nurses working in the community. We cannot at present determine these educational needs, so our recommendations are based on the current first-level preparation for nurses.

1.15 The recommendations will have implications for other health professionals, such as clinical medical officers and pharmacists, who might see a case for their being enabled to engage in some form of prescribing activity. We believe that such developments should be considered separately.

1.16 Although our recommendations may affect some nurses who work at least in part in hospital settings, it is not our intention that they should apply to patient care within hospitals. We think that nurse prescribing in hospitals should be considered separately.

The case for nurse prescribing

1.17 We have endeavoured to keep our thinking closely in line with our understanding of the spirit and intentions of the Community Nursing Review Team. There is no question of our recommendations turning nurses into "mini-doctors". GPs will continue to have the overall and continuing responsibility for the treatment of patients on their lists, and we believe that prescribing by nurses must always take place with the full agreement and awareness of the patient's GP. However, nurses are responsible professionals and we take the view that if their work requires them to take clinical decisions about treatment, they should be responsible for the prescription of items required for that treatment. The nurse must prescribe against a background of general agreement and awareness and must take every step to inform the GP responsible of her actions, but she alone is accountable for her decisions at the point of issue of a prescription.

1.18 With these considerations in mind, we have identified a number of clear benefits which we believe will follow from a limited extension of authority to prescribe to some nurses. Foremost among these is a significant improvement in patient care. With shorter hospital stays and increasing emphasis on community care, there is a growing demand for the skills of community nursing staff, yet their full development is to some extent inhibited by the lack of prescribing rights. The nurse who plans and carries through a programme of care has close and continuing contact with the patient and is uniquely placed to make an accurate assessment of that patient's needs. The nurse will be expected to maintain up-to-date knowledge, based on critical professional appraisal, of the products available to meet the patient's needs, for those areas of care for which the nurse takes responsibility.

1.19 We believe that a limited extension of the authority to prescribe will enable the nurse to manage a patient's condition, or combination of conditions, more effectively. This will undoubtedly be seen as a natural development by many patients and will, we believe, strengthen the nurse/patient relationship significantly. The authority for suitably skilled community nursing staff to adjust the timing and dosage of medicines will particularly benefit terminally ill patients receiving care at home.

1.20 A further important benefit will be better use of the patient's and the nurse's time. Time is precious to patients and professionals alike, and we believe that nurses could make more appropriate use of their time if they were able to prescribe certain items rather than having to ask GPs to do so. This would also help patients to receive treatment with the minimum of delay.

1.21 Finally, we believe that nurse prescribing will lead to a welcome clarification of professional responsibilities. We think that the practice of doctors having to sign prescriptions for items used by nurses is undesirable and professionally demeaning for all involved. Our aim is to ensure that the individual responsible for clinical decisions about treatment should also be responsible for the prescription of items required for that treatment. The organisational and administrative arrangements for nurse prescribing must therefore always make clear which health professional is responsible. We believe that such clarification will strengthen professional partnership in the primary health care team. That, combined with the improved communications between team members which should result from our proposals, can only be beneficial to patient care.

1.22 For all these reasons, the advisory group believes that some authority to prescribe from a limited list of items should be extended to nurses and that, in certain clearly defined circumstances, nurses might vary the timing and dosage of medicines previously prescribed by a doctor. We believe that in this form nurse prescribing is firmly in line with the Government's aim, stated in its recent White Paper "Working for Patients" (6), of making the health service more responsive to the needs of patients. The introduction of nurse prescribing would help to ensure that the best possible use is made of available resources by all those concerned with the delivery of services. We hope that the Government's proposals for strengthening the management of family practitioner services will provide an opportunity to establish rational prescribing arrangements across the primary care and hospital services and that our recommendations will play a valuable part in that process.

1.23 We had hoped to be able to support the case for nurse prescribing by referral to experience in other countries as well as by our analysis of the present situation and opportunities in the United Kingdom. We have not, however, been able to find reports of such experience in countries with comparable health care systems.

1.24 The remainder of this report sets out the advisory group's views on:

- the categories of nurses who should be allowed to prescribe;
- the products which should be available to them;
- the administrative arrangements which will be required to introduce nurse prescribing;
- the educational, legal and economic implications of such a change.

We also propose a schedule for implementation of our recommendations and put forward suggestions for the evaluation of this alteration in service to patients.

RECOMMENDATION 1

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.

CHAPTER 2

THE CIRCUMSTANCES IN WHICH NURSES SHOULD BE ABLE TO PRESCRIBE

2.1 The advisory group is keen that its recommendations should be robust enough to withstand likely future changes in organisational structures and administrative arrangements in the National Health Service (NHS). In considering the circumstances in which nurses should be able to prescribe it therefore took patients and their clinical problems in the community as the stable focus of need around which services must develop.

2.2 Having accepted the basic concept of nurse prescribing, the advisory group set out to identify the clinical circumstances in which prescribing by nurses would improve patient care. Only when these had been defined could we form conclusions about the kinds of nurses who should have prescribing rights and the products which they should be able to prescribe.

2.3 We began by identifying three sets of circumstances in which patient care would be improved if nurses were able to prescribe, supply or adjust the timing and dosage of certain medicines. These are:

- the care of individual patients, when the nurse is the responsible practitioner;

- the care of groups of patients within a clinical protocol;

- the care of individual patients within a patient-specific clinical protocol.

We therefore recommend that certain groups of nurses (as specified in Chapter 3) should be able to:

A. Prescribe from a Nurses' Formulary (see Chapter 4) for individual patients receiving care for a condition for which the nurse takes clinical responsibility eg the management of post-operative wounds or a varicose ulcer. We refer to prescribing in this situation as initial prescribing.

B. Supply within a group protocol agreed by the professionals responsible for a particular clinical service. The protocol should include arrangements for initial assessment and review.

C. Adjust timing and dosage of medicines for individual patients within a patient-specific protocol.

A. Individual patients: initial prescribing

2.4. The biggest category of patients who would benefit from nurse prescribing is probably that envisaged by the Community Nursing Review Team - patients at home, under the care of a GP, with a clinical condition which requires in addition the professional expertise of a nurse member of the primary health care team. Some of these conditions will require treatments which include dressings and appliances, and it is in the provision of these items to patients in their own homes that time is frequently wasted, for although the GP may delegate his responsibility to the nurse and she decides what is required, a doctor has to write the prescription. Good examples are (1) the management of post-operative wounds, where the nurse normally assesses the condition, decides on the most appropriate treatment (including the products to be used) and monitors progress, and (2) stoma and catheter care.

2.5 Initial prescribing by nurses may also prove particularly beneficial in work with groups such as homeless families, travellers and other disadvantaged people who may not be registered with a GP and are unwilling or unable to use medical services. This particular aspect of nurse prescribing is considered further in Chapter 9.

B. Groups of patients: arrangements for supply to certain categories of patients of items within a group protocol

2.6 There are some areas of clinical practice in which the management of the majority of patients is relatively routine. The normal sequence is that patients are assessed according to a group protocol, which has been agreed by all the professionals responsible for a particular clinical service, and, provided there are no contra-indications, a standard programme of management is instigated and monitored. The protocol should include arrangements for the initial medical assessment of each patient and for the clinical review immediately prior to the procedure, which does not necessarily require the direct involvement of doctors but must of course be in the hands of appropriately trained and experienced nurses. A good example here is the immunisation and vaccination of infants and children at GPs' surgeries.

2.7 Although we are talking about the supply of items within a group protocol, we are not suggesting a change in the current arrangements for prescribing and dispensing. In general, we envisage nurse prescribing as being limited to those items listed in the Nurses' Formulary. If the group protocol is for continuing care (eg stoma care) rather than a single episode like immunisation, it may exceptionally be in the patient's interest for the nurse to prescribe a small initial supply to a patient as a starter dose. The patient should obtain subsequent supplies in the normal way, ie via a prescription issued by the GP having overall responsibility for the patient or by a nurse, which would be presented to a pharmacist for monitoring and dispensing as at present.

C. Individual patients: adjusting timing and dosage of medicines within a protocol (patient-specific protocols)

2.8 Many nurses in all areas of practice take decisions about the timing and dosage of medicines already prescribed for a patient in accordance with their own clinical observations, their knowledge of the intentions of their physician colleague, or a written treatment protocol. There are many areas of care, involving trained community nursing staff and specialist nurses, where this arrangement is clearly working well. This may be particularly beneficial in the control of pain and other symptoms in terminally ill patients, in the case of people with diabetes, and in the management of chronic psychiatric illness such as schizophrenia or dementia.

RECOMMENDATION 2

We recommend that certain specified groups of nurses should be able to:

- **prescribe from a Nurses' Formulary (initial prescribing);**
- **supply within a group protocol agreed for a particular clinical service. The protocol should include arrangements for initial assessment and review;**
- **adjust the timing and dosage of medicines within a patient-specific protocol.**

We specify the particular nurses who we propose should be able to carry out each function in Chapter 3.

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CHAPTER 3

THE CATEGORIES OF NURSES TO BE AUTHORISED TO PRESCRIBE

3.1. We are concerned that our recommendations should be able to withstand future organisational changes in community nursing. We have therefore attempted to frame our views in the context of the nursing tasks to be performed, rather than fixing them in contemporary job titles. We have of course used the names with which everyone is familiar - district nurse, health visitor - but wish to make it clear that the basic principles of our recommendations should apply to nurses providing similar care and with appropriate qualifications, regardless of the titles which may be given in the future.

3.2 The advisory group considers that the authority to prescribe for patients, or to adjust the timing and dosage of medicines, must be associated with a clear responsibility for clinical care and management. We believe that appropriately qualified nurses are able to discharge such responsibilities in certain clearly defined circumstances. We do not think that there are any circumstances in which student nurses, or nurses who have not obtained a specific post-registration qualification, should be empowered to prescribe. We believe that a clearly defined appropriate post-registration qualification is essential if nurses are independently to adjust the timing and dosage of medicines, although we recognise that any nurse can be requested by a doctor to do so.

3.3 The majority of the nurses who might be authorised to prescribe in the future will, if present administrative arrangements in the NHS remain unchanged, be employees of Health Authorities, who work in the community, often as members of primary health care teams. At present there are some

28,000 trained district nurses and health visitors in the United Kingdom. Appendix D gives the categories and numbers of other nurses working in the community. They include nurses working in schools and hospital-based nurses with community involvement, such as stoma care nurses. Practice nurses (4000 whole-time equivalents in 1988, Great Britain) and private nurses in the community may also have post-registration qualifications, but no records of these are available. The advisory group has endeavoured to bear in mind the needs of the minority groups of nurses working in the community, and their patients, in framing its recommendations.

"Initial" prescribing

3.4. The clinical circumstances in which we believe nurses should be empowered to prescribe are set out in Chapter 2. We have reached the view that, for the present, authority for initial prescribing from the Nurses' Formulary should be introduced for nurses with a district nurse or health visitor qualification only. In order to prescribe, they must be registered general nurses and registered health visitors, or have the district nursing certificate recorded on the register maintained by the UKCC. We believe that the education and training for health visitors and district nurses should be modified to give them the necessary professional competence to undertake their initial prescribing role. Their training courses already contain a pharmacological component, although further education and training will be needed for those already qualified as health visitors and district nurses. Education and training requirements are considered in detail in Chapter 5.

3.5 Nurses with health visitor or district nurse qualification and appropriate education and training should be authorised to prescribe even if employed in some other capacity, eg as paediatric community nurses, practice

nurses or private nurses. They would be subject to the same conditions as other nurses who prescribe. Private nurses would, of course, only be able to write private prescriptions.

3.6 We gave careful consideration to the position of community psychiatric nurses (CPNs) with regard to "initial" prescribing. We concluded that it would not be appropriate for them to become "initial" prescribers at present; nor do we believe this to be sought by the majority of CPNs. The CPNs' dual responsibility to both the GP and the hospital consultant could lead to problems of co-ordination and communication, and their close relationship with the patients could result in their coming under unacceptable pressure to prescribe.

3.7 We also gave consideration to other groups of specially trained nurses and concluded that we could not recommend that they should be able to undertake initial prescribing at present. Specialist nurses are often based in hospital settings and visit fewer patients in their homes than district nurses and health visitors. Their working relationships with GPs are less close and it is often easier for them to obtain supplies from Health Authorities, so making it less important to be able to prescribe.

3.8 For these reasons, we think that the role of the specialist nurse should primarily be to advise the district nurse or health visitor about the care of patients, for whom the district nurse or health visitor might then prescribe on her own authority. For example, stoma patients may require detailed advice on appliances, skin care and diet from an experienced stoma care nurse who will usually see the patient in a hospital or clinic and may provide appliances from hospital stock. The patient may, however, need repeat prescriptions and regular visits by a district nurse who could prescribe on the advice of specialist colleagues.

3.9 Once initial prescribing by district nurses and health visitors has been introduced and evaluated, we recommend that consideration should be given to extending initial prescribing authority to other groups of specialist nurses.

Supply within group protocols

3.10 We think that there are some areas of clinical practice where it would be appropriate for specially trained nurses, in addition to nurses with a district nurse or health visitor qualification, to be able to supply certain categories of patients with items within group protocols. The concept of the group protocol is likely to be most appropriate in community-based clinics or in specialist areas at present based in hospitals, and - apart from the immunisation and vaccination of infants and children (see paragraph 3.11) - does not apply easily to GP practices. We recommend that the following groups of nurses should, in certain specified circumstances, be allowed to supply within group protocols:

Stoma Care Nurses should be able to supply items from the Nurses' Formulary in relation to stoma care. They must be RGNs who have completed the current National Board Course in Stoma Therapy, which is a qualification recorded on the register maintained by the UKCC.

Continence Advisers should be able to supply items from the Nurses' Formulary in relation to advising on continence. They must be RGNs who have completed an extended course in Continence Advising approved by a National Board which should include a prescribing module. (The course as it stands requires further consideration.) The qualification should meet the criteria of the UKCC for recording on the professional register.

School Nurses should be able to supply items from the Nurses' Formulary in relation to school nursing activities. They must be Registered General Nurses or Registered Sick Children's Nurses who have completed the current National Board approved School Nurse Course which is recorded on the register maintained by the UKCC.

Paediatric Clinical Nurse Specialists should be able to supply items from the Nurses' Formulary in relation to the care of children with special needs in the community. They must be Registered Sick Children's Nurses who have completed a specialised course in paediatric nursing approved by a National Board eg Paediatric Oncological Nursing. These nurses are hospital-based and do not possess the district nurse certificate as do their paediatric community nurse colleagues.

We believe that the needs of patients in these areas and the specialist practice of nurses working within them makes them particularly appropriate for management by a group protocol.

3.11 The supply of vaccines for infants and children by nurses with a district nurse or health visitor qualification is an example of an item suitable for a group protocol. A number of Health Authorities have produced guidance for good practice, a good example being the "Vaccination Training Procedure - Manual for Trainers" produced by Nottingham Health Authority (7).

Altering the timing and dosage of medicines within a patient-specific protocol

3.12 We think that certain groups of specially trained nurses should be able within a patient-specific protocol to alter the timing and dosage of specified medicines which have been prescribed by a doctor. We recommend that nurses

with a district nurse or health visitor qualification should be given this authority. In addition, we recommend that the following specialist nurses should be able to vary the timing and dosage of medicines for patients under their professional care:

Community Psychiatric Nurses and Community Nurses for the Mentally Handicapped provided they are either Registered Mental Nurses or Registered Nurses for the Mentally Handicapped and have completed the current courses for Community Psychiatric Nursing or Community Courses for Nurses for the Mentally Handicapped approved by a National Board. The qualifications should meet the criteria of the UKCC for recording on the register.

Specialist Diabetic Liaison Nurses provided they are Registered General Nurses and have completed a National Board approved course which should include a prescribing module. (At present, current courses are not acceptable.) The qualification should meet the criteria of the UKCC for the recording of the qualification.

Specialist Nurses for Terminally Ill Patients provided they are Registered General Nurses and have completed the extended English National Board approved course which leads to a recordable qualification in nursing the terminally ill.

3.13 These groups of specialist nurses should all have received education and training to enable them to accept the responsibility for altering the timing and dosage of medicines. Nurses in these groups who do not currently meet the requirements should receive additional education and training to enable them to vary the timing and dosage of medicines to patients under their professional care.

Other specialist nurses

3.14 We considered whether nurses working in drug and alcohol dependency units should be allowed to supply medicines within a group protocol or to adjust the timing and dosage of medicines. Difficult issues are raised in this clinical field because of the patients' problems, and the possibility of excessive pressure being put on nurses who can prescribe or supply medicines, as well as the risks related to medicines which may be open to misuse. We therefore concluded that these nurses should not be given this authority at present but that the position should be reviewed in the future when the introduction of nurse prescribing has been evaluated.

3.15 Difficult and controversial issues were also raised in relation to the supply of medicines within a group protocol by family planning nurses, who provide skilled professional contraceptive advice in family planning clinics and in domiciliary services. In many respects this is an ideal situation for the supply of medicines by nurses. But we recognise that the question of whether nurses should be able to supply oral contraceptives to patients raises contentious issues. We are firmly of the view that oral contraceptives should only be prescribed after a full clinical assessment to identify any contra-indications, and that the individual patient should continue to be carefully monitored. On balance, therefore, the advisory group concluded that family planning nurses should not be authorised to supply medicines at the present time. We consider that the role of family planning nurses should be considered separately in the very near future, to link with the forthcoming revision of family planning nurse training.

3.16 The list of specialist nurses authorised to supply medicines within a group protocol or to change timing and dosage will need to be reviewed from time to time to take account of changes in patterns of patient care and of clinical practice.

Requirement to prescribe

3.17 In the future, as a result of our recommendations, the ability to prescribe will be an accepted area of nursing practice for certain nursing posts. In such cases, the job description should make clear that the post holder will be required to prescribe and should specify the qualifications needed. Nurses who accept such posts must therefore be prepared to take on prescribing responsibility.

3.18 Appropriately qualified district nurses and health visitors currently in post should be offered the opportunity to undertake extra education and training (Chapter 5) to become prescribers. They cannot, however, be required to do so since their employing authority can normally only alter their job description with their agreement.

3.19 All registered nurses, midwives and health visitors are professionally accountable for their practice and subject to the UKCC "Code of Professional Conduct for the Nurse, Midwife and Health Visitor" (8) which, together with associated UKCC papers, gives definitive advice on professional conduct. All cases of alleged misconduct which would include complaints against nurses in respect of prescribing would be dealt with by the statutory bodies (the National Boards and the UKCC). In addition, nurses, midwives and health visitors are subject to the disciplinary policies and procedures of their employing authorities. Complaints against nurses in respect of prescribing would be dealt with either by their employers (for managerial matters) or by the UKCC (for professional matters).

RECOMMENDATION 3

Nurses with a district nurse or health visitor qualification (including those employed as paediatric community nurses, practice nurses or private nurses), having had the necessary additional training:

i. should be empowered to prescribe items necessary for the care of patients with those conditions for which the nurse takes independent clinical responsibility;

ii. should be able to supply certain categories of patients with items within a group protocol and adjust the timing and dosage of medicines within a patient-specific protocol.

RECOMMENDATION 4

Supply within a group protocol. In addition to nurses with a district nurse or health visitor qualification, certain groups of nurses who have successfully completed the appropriate specialist education, training and assessment should be able to supply certain categories of patients with items within a group protocol. At present, we recommend that stoma care nurses, continence advisers, school nurses and paediatric clinical nurse specialists should be given this authority.

RECOMMENDATION 5

Adjusting timing and dosage of medicines. In addition to nurses with a district nurse or health visitor qualification, certain community nursing staff who have successfully completed appropriate specialist education,

training and assessment should be able within a patient-specific protocol to adjust the timing and dosage of medicines which are prescribed by medical practitioners.

At present we propose that community psychiatric nurses, community mental handicap nurses, specialist nurses for terminally ill patients and diabetic liaison nurses should be given this authority.

RECOMMENDATION 6

Further consideration should be given, in the light of experience, to extending initial prescribing authority to some other groups of specialist nurses.

RECOMMENDATION 7

The groups of specialist nurses identified in recommendations 4 and 5 as authorised to supply items, or adjust the timing and dosage of medicines, should be reviewed from time to time to take account of changes in clinical practice, and the role of family planning nurses should be considered in this context.

RECOMMENDATION 8

A nurse who accepts a post for which the ability to prescribe, supply or adjust the timing and dosage of medicines is a requirement set out in the job description will be expected to accept this responsibility.

CHAPTER 4

THE PRODUCTS TO BE PRESCRIBED BY NURSES

4.1. In Appendix E, we set out a list of the broad groups of products which we think should be available to authorised community nursing staff for initial prescribing. It is intended to be illustrative only and should not be regarded as a definitive proposal. It has been drawn up in accordance with certain general principles.

4.2. In considering the content of the proposed Nurses' Formulary the advisory group was guided by the principle that nurses should be able to prescribe the items necessary for those areas of clinical care for which they take prime responsibility.

4.3 We do not think that nurses should be able to prescribe any items within the NHS which cannot be prescribed within the NHS by GPs.

4.4 We had considerable discussion about extending the Formulary's range to include medicinal products which can be purchased by members of the public in a pharmacy, over the counter, such as mild analgesics, laxatives and cough suppressants. We could find no professional reason why (provided such items continued to be prescribable within the NHS) nurses should not be able to prescribe such items. We recognise, however, that such a move could have significant cost implications and have therefore included only a limited range in our proposed Formulary.

4.5 The problems of nurse prescription of medicines and dressings which are currently "Prescription Only Medicines" (POM) are more difficult. We considered whether the Nurses' Formulary should include antibiotics, for either systemic or topical application, anti-fungal agents (for the treatment of, for example, thrush) and antiseptics. In this we were guided by our view that nurses should be able to prescribe for those areas of clinical care for which they have prime responsibility. However, we also believe that it is essential that the individual who prescribes for a particular condition, such as an infection, should have the skills and experience to diagnose the condition accurately and be aware of the possible differential diagnoses. In some instances, inappropriate treatment may mask the underlying condition and delay effective treatment. In other cases, an infection may indicate the presence of another disease which requires expert assessment and treatment. The training of doctors is aimed essentially at the skills of diagnosis, while the training of nurses is not. However, nurses with the qualifications and experience which we have already identified as being required for potential prescribers will have considerable knowledge of the common conditions encountered in their areas of practice. There could be significant benefit to patient care if nurses were able to provide rapid treatment of minor infections. We therefore think that the Nurses' Formulary should include an anti-fungal agent - the present choice would be nystatin. There are good clinical reasons, particularly in the treatment of babies and elderly people, for nurses to be able to prescribe nystatin, though we do not think it would be appropriate for nurses to prescribe other antibiotics.

4.6 There are also in our view good clinical reasons for the inclusion of the two other POMs in the illustrative Formulary, Iodosorb and Varidase, which are known to be regularly used in clinical practice to promote wound healing.

4.7 We recommend that the Nurses' Formulary should include the dressings, appliances and chemical reagents contained in parts 9 A, B, C and R of the Drug Tariff, subject to the following exceptions in part IXA:

- contraceptive devices, apart from fertility thermometers (see paragraph 3.15);

- gauze dressings (impregnated), apart from paraffin gauze dressing and BP sterile (because it is not clinically appropriate for nurses to prescribe them);

- hydrocortisone and silicone bandage (a POM product - again, because it is not clinically appropriate for nurses to prescribe this).

4.8 We propose that all authorised district nurses and health visitors should be able to prescribe all the items in the Nurses' Formulary.

4.9 Items for which nurse prescribers might vary timing and dosage, or supply direct to patients, should be determined in locally agreed clinical or patient-specific protocols.

4.10 We suggest that a Departmental working group should be established without delay to bring forward detailed proposals for the content of the Nurses' Formulary, taking account of the general principles set out in this report.

4.11. The Nurses' Formulary, once agreed with the medical, nursing and pharmaceutical professions and embodied in appropriate legislation, will have to be published in a suitable form and reviewed on a regular basis to take

account of clinical and pharmaceutical developments. The regular review could be the responsibility of a special group similar to the one responsible for the Dentists' Formulary (Dental Practitioners Formulary Sub-Committee). In the short term, we think that the use of the Formulary should be evaluated and monitored in some detail, and proposals for this are included in Chapter 10.

RECOMMENDATION 9

A Nurses' Formulary should be drawn up by the Department of Health, in consultation with the appropriate professions, to include the groups of medicines, dressings and appliances, and diagnostic agents set out in Appendix E.

RECOMMENDATION 10

The Nurses' Formulary should be reviewed regularly, taking account of appropriate professional advice.

CHAPTER 5

NURSE EDUCATION AND TRAINING

5.1. Nurses who are authorised to prescribe or to alter the timing or dosage of medicines must receive appropriate education and training. This training will include pharmacology, therapeutics and practical aspects of prescribing. It should aim to encourage critical professional appraisal of the evidence on the effectiveness and suitability of the items which can be prescribed. The advisory group hopes that the introduction of nurse prescribing will encourage the development of related nursing research.

5.2 Many existing nurses working in the community have undertaken specific post-registration courses and obtained a district nurse or health visitor qualification. Some community nursing staff have no formal post-registration qualifications (eg some registered general nurses, some practice nurses, some nurses in private practice and nursing homes).

5.3. In considering the issues of education and training, the advisory group addressed three main areas:

- the educational needs of nurses at present appropriately qualified as potential prescribers;

- changes which may be needed in education programmes for nurses who may in the future become prescribers;

- continuing education for nurse prescribers.

5.4 To assist the advisory group with this work, the professional secretariat undertook a series of visits to educational establishments and conducted interviews with specialist nurses. We are very grateful for the detailed information on the content of existing nurse education and training which this work yielded, and for the helpful suggestions for additional training requirements which have been made to us. Appendix F summarises the education and training undergone by various groups of nurses and indicates whether their existing courses would need to be extended in order to include instruction in pharmacology, therapeutics and practical prescribing.

5.5 We recommend that the UKCC be invited to devise a policy aimed at ensuring that all nurses currently holding health visitor and district nurse qualifications receive such additional education, training and assessment as will enable them to demonstrate to a National Board for Nursing, Midwifery and Health Visiting adequate knowledge of pharmacology and therapeutics relevant to the products which they may subsequently be authorised to presribe.

5.6 We consider that, with the exception of continence advisers and specialist diabetic liaison nurses, the specialist nurses identified in paragraphs 3.10 and 3.12 as suitable to supply medicines within a group protocol, or to alter the timing and dosage of medicines, are already well enough trained to undertake this work. The present courses for continence advisers and specialist diabetic liaison nurses will need to be extended and developed to include more pharmacology, and also to meet the criteria of the UKCC for the qualification to be recorded on the register.

5.7 All the nurses affected by our recommendations will need training in the safe and secure handling of medicines. This must comply with the recommendations of the report "Guidelines for the Safe and Secure Handling of Medicines" (9).

5.8 The necessary education programmes should be made available to community nursing staff currently in post before nurse prescribing is introduced.

5.9 In future we envisage that it should be possible for instruction in pharmacology, therapeutics and practical prescribing to be incorporated into the initial health visitor and district nurse courses without any extension of the duration of the course. Other relevant courses should be amended as necessary.

5.10 Nurse prescribers will require continuing education for this aspect of their work as they do for all others. They should be assisted to keep abreast of clinical and therapeutic developments in their areas of practice. The advisory group was concerned that, notwithstanding the limited nature of nurse prescribing, pharmaceutical companies and other suppliers might attempt to have undue influence on continuing education, in the hope of persuading nurses to prescribe specific products. We consider, therefore, that all aspects of nurse education policy and provision should remain the responsibility of professional bodies, and that no events wholly arranged or resourced by commercial companies should be recognised for formal training purposes.

5.11 Each nurse prescriber will have a professional responsibility to keep her knowledge fully updated so that she can carry out her prescribing role effectively and safely. Her employing authority should ensure that the necessary opportunities are available.

RECOMMENDATION 11

The UKCC should be invited to devise a policy aimed at ensuring that all nurses currently holding district nurse and health visitor qualifications receive such additional education, training and assessment as will enable them to demonstrate to a National Board for Nursing, Midwifery and Health Visiting adequate knowledge of pharmacology and therapeutics relevant to the products which they may subsequently be authorised to prescribe.

RECOMMENDATION 12

In future, all post-registration courses in health visiting and district nursing should include tuition and assessment to a level to be determined by the National Boards in pharmacology, therapeutics and practical prescribing. The present courses for continence advisers and specialist diabetic liaison nurses should be extended to include these subjects.

RECOMMENDATION 13

The UKCC and National Boards should be responsible for all aspects of policy in relation to nurse education and training, and for the provision of formal courses. No events wholly arranged or resourced by commercial companies should be recognised for formal training purposes.

CHAPTER 6

PROFESSIONAL COMMUNICATIONS

6.1. Good communications between health professionals and patients, and between different professionals, are essential for high quality health care.

6.2. The introduction of nurse prescribing could play a significant part in improving communications within primary health care teams and between other health professionals working in the community, and hence could improve the quality of health care. Effective collaboration between the nurse prescriber and GP will always be essential since the GP will retain overall responsibility for patients on his list. We believe that the clarification of professional responsibilities which should result from nurse prescribing will lead to a strengthening of that working relationship and enable each partner to exercise their own skills to best effect. Effective collaboration will be essential to avoid either duplications or omissions in prescribing.

6.3. The acceptance of prescribing responsibility brings an implicit requirement for the clear and unambiguous recording of information, and for that information to be shared between nurse and doctor and any other health care professional involved in the patient's care.

6.4. In Appendix G we have set out guidelines for good practice in communications. National "rules" may be too rigid for matters such as communications, where many local issues have to be taken into consideration, but we commend these guidelines to professionals as a basis for the development of local policies.

6.5. Nevertheless, we feel that on one point there should be total consistency. Once nurse prescribing is introduced it is essential that nurse prescribers have access to the relevant clinical records of the patients for whom they have prescribing responsibility.

6.6. The advisory group was concerned not only about the development of good communications between prescribing doctors and nurses, who are often already working in teams and have developed frameworks for professional communication, but also about the development of links between nurse prescribers and pharmacists. The pharmacist takes responsibility for the issue of medicines to a patient or his representative, on production of a prescription, and may himself supply certain items not on prescription.

6.7 It is essential that pharmacists should be able to confirm with ease that a particular prescription is valid and it is, of course, always desirable that they should know details of a patient's total medication, so that they can advise the patient and alert prescribers to the possibility of problems such as potential adverse reactions and interactions.

6.8. Many pharmacists know the GPs in their district and often have long-standing knowledge of the patients. It is desirable that steps be taken to develop similar professional links between prescribing nurses and pharmacists. Inevitably, such personal contact will be easier to develop in rural areas and small towns than in conurbations where the sense of neighbourhood is less well developed.

6.9. As well as these desirable informal contacts, pharmacists must have:

(a) access to relevant patient medication records (eg patient-held records);

(b) a means of contacting a central list of nurse prescribers, to confirm that a specific individual is authorised to prescribe (see paragraphs 3.4, 7.3 and 7.7);

(c) a contact point for individual prescribers in case there is a need to clarify a specific prescription (see paragraphs 7.15 and 7.16).

6.10. In chapters 2 and 3 we introduced the concept of the group protocol and the patient-specific protocol. We consider these written documents to be essential for the satisfactory introduction of some aspects of nurse prescribing. In Appendix H we set out guidelines for the production of protocols. Again, we have not tried to produce national rules, but are convinced that satisfactory local ones should be produced by the authorities responsible for service delivery, and should be made available to all professionals involved. We believe that the production of the protocol itself will provide an opportunity to improve professional communications and may well lead to clarification of some clinical issues which have not in the past been the subject of rigorous discussion. Pharmacists could with advantage be involved in the development of clinical protocols.

6.11. Although we envisage that our recommendations for nurse prescribing can be implemented widely without difficulty, because they are based on the principle of prescribing responsibility being linked to clinical responsibility and personal professional accountability, there will inevitably

be some problems between professionals. Difficulties can arise if the doctor and nurse do not agree on a particular form of treatment, or if a pharmacist is unwilling to issue a specific product for professional reasons. We hope and expect that these instances will be rare. In the event of a disagreement, however, we propose that, as at present, the GP responsible for the care of the patient should take the final decision on treatment. The pharmacist must retain the right not to issue the medicines prescribed if he considers that it is professionally improper to do so.

6.12. The advisory group discussed at length the problems of maintaining in the community adequate and up-to-date patient records which would be immediately available to all nurse and doctor prescribers who may need to see them. Even when everyone is committed to excellent communications and where computerised systems are advanced and compatible, the record cannot be in the practice premises and with the visiting nurse at the same time. We are totally opposed to separate patient records held by different health professionals and think that proper inter-professional communication can only be achieved where there is an integrated patient record.

6.13. We concluded that a patient-held record which contains information on the patient's diagnoses and allergies and the timing and dosage of all medication, and is completed by each professional who prescribes for the patient, would be ideal. District nurses already leave a nursing record with the patient, so this would be a natural extension. Information from the patient-held record should be entered into the patient's central, surgery-held, record as soon as possible. Experience with patient-held obstetric and child health records has been good and we believe that a patient-held medication record would be of enormous value to the doctor, nurse and pharmacist - and hence to the quality of care the patient receives.

RECOMMENDATION 14

Good communications between health professionals and patients, and between different professionals, are essential for high quality health care. All health professionals empowered to prescribe for a patient should have access to the relevant patient records.

RECOMMENDATION 15

In every Health Authority, a group protocol agreed for a particular clinical service should be drawn up by those responsible for service delivery, using a working group which includes representatives of the doctors, nurses and pharmacists involved. The protocols must be written, regularly reviewed and issued to all relevant health professionals.

RECOMMENDATION 16

"Patient-specific protocols" should be drawn up by all the practitioners responsible for the care of the patient. These protocols must be written, with copies in the patient's records and available to all authorised prescribers for the patient and to pharmacists, as necessary.

RECOMMENDATION 17

In the event of a disagreement between professionals over the treatment of a patient, the GP responsible for the care of the patient will, as at present, take the final decision.

RECOMMENDATION 18

The pharmacist must retain the right not to dispense a prescription on professional grounds.

RECOMMENDATION 19

Patients' personal record cards showing the timing and dosage of all medication, and other relevant information, should be completed by each professional who prescribes for the patients and updated to show any changes. They should be available to doctors and nurses treating the patient and to pharmacists issuing medicines. Patient-held records of medication should be used wherever possible.

CHAPTER 7

ADMINISTRATIVE ARRANGEMENTS

7.1 The introduction of a major change, such as we propose for nurse prescribing, into a complex organisation like the National Health Service inevitably brings with it the requirement for amended administrative arrangements. These are necessary for the protection of the public. The people who are authorised to prescribe for patients must be identified and their skills confirmed. The products to which they have access must be clearly identified. Systems are also necessary in order to establish managerial and financial control over the use of public money and other resources.

Identification of "nurse prescribers"

7.2 We have set out in Chapter 3 the qualifications which we consider necessary for a nurse prescriber, who should hold a health visitor or district nurse qualification and have obtained the necessary additional training in prescribing.

7.3 We propose that the UKCC be asked to undertake the responsibility of identifying authorised nurse prescribers by use of its professional register.

7.4 All nurse prescribers must have a currently effective registration with the UKCC. At a given date, when the prescribing module has been incorporated into initial health visitor and district nurse training courses, the possession of a Certificate in Health Visiting or District Nursing will be sufficient to identify that the nurse is an authorised prescriber. Until then, nurse prescribers will be identified by their qualification as a health visitor or district nurse, together with a record of successful completion of prescribing training approved by a National Board (paragraph 5.5).

Identification of nurses qualified to supply medicines within group protocols and adjust timing and dosage of medicines

7.5 We propose that all nurses supplying medicines within group protocols and adjusting the timing and dosage of medicines should have completed a post-registration course as specified in Chapter 5 that meets the conditions specified by the UKCC and is approved by a National Board. This means that the UKCC can confirm the qualifications held by a nurse to any approved enquirer.

7.6 We envisage that, as part of their verification service, the UKCC will be able to identify authorised prescribers and confirm for bona fide professional enquirers that individual nurses are empowered to prescribe. This would provide a means by which an individual nurse might establish her status as a nurse prescriber with a pharmacist or other professional colleague. It should be the responsibility of each nurse to ensure that her qualifications are registered or recorded with the UKCC. The employing authority and others involved in agreeing protocols must make sure that she has done so. Employing authorities should also maintain records of nurses in their employment who are authorised prescribers.

7.7 In most cases, patients or their agents will be calling at pharmacies with prescriptions, rather than the nurse herself. We are not, after all, recommending a "drug delivery by nurses" system. It may, however, be worth considering introducing a form of identification for nurse prescribers which includes a photograph, to assist in cases of difficulty. The UKCC already issues plastic cards giving the number by which all nurses, midwives and health visitors can be identified on the UKCC register, but this could not be used as a means of identifying authorised prescribers.

Identification of products available to nurse prescribers

7.8 We have discussed in Chapter 4 the way in which a Nurses' Formulary should be established, and propose that the Department of Health produce as soon as possible a detailed list, with the advice of the professions involved. This should be published and reviewed regularly. Arrangements will be needed to distribute this list to authorised nurse prescribers and other professionals.

Identification of "cost centres"

7.9 At the present time, most of the products which we envisage that nurses might prescribe are supplied to patients in the community by their GPs and are charged to the budget of the Family Practitioner Committee (FPC). The nurses who are likely to take over some of this prescribing responsibility are, however, at present mainly employed by Health Authorities. It would not be reasonable to expect FPCs to accept costs incurred by the activities of staff not in their employment and over whom they have no control.

7.10 On the other hand, it is unrealistic to expect Health Authorities to accept charges currently quite properly being met by FPCs. We are aware that prescriptions written by hospital doctors and dispensed by community pharmacists are currently charged to the hospital or Health Authority concerned. Nevertheless, we believe that a system of payment by Health Authorities for nurse prescriptions dispensed in the community would be unnecessarily expensive and contrary to the principle of charges falling in the appropriate sector of the health service.

7.11 The advisory group encountered great difficulty here, largely because it was trying to devise a rational solution to a basically irrational situation. Our view is that the only realistic proposal is for all authorised nurse prescribers working in the National Health Service to have honorary contracts with the appropriate FPC so that FPCs would have some control over the staff whose prescribing costs they were meeting.

7.12 We are optimistic that the Government's proposals in "Working for Patients", for making FPCs accountable to Regional Health Authorities, so bringing together responsibility at strategic level for primary health care, hospital services, and their respective medicines budgets, will do much to overcome present difficulties and make complex administrative arrangements for nurse prescribers unnecessary. We hope that the opportunity will not be lost to establish rational prescribing policies across both the family practitioner services and hospital and community health services within each Region.

7.13 We note that the Government's working paper "Indicative Prescribing Budgets for General Medical Practitioners" (10) proposes that the allocation to FPCs for medicines budgets should include the costs of any prescribing by nurses to be attributed to the FPC budget. We are aware that further work is now under way on the detailed implications of this proposal. We believe it is essential that careful account should be taken of our recommendations, and any likely cost implications, so that appropriate allocations for nurse prescribing can be made from the outset within the new budgets.

7.14 Whatever arrangements are introduced, it will be essential that systems are established for the regular monitoring of nurse prescribing patterns, with reports from the Prescription Pricing Authority to the nurse prescribers themselves. In our view, this will mean that each nurse will effectively need to be a "cost centre". We did not consider it feasible to relate prescribing costs back to the patient's GP, as many community nurses deal with patients of several GPs, and they may be dealing with some patients who are not registered with GPs.

Practical prescribing arrangements

7.15 Authorised nurse prescribers working within the NHS will need prescription pads which should be issued in the same way as those for GPs. Nurse prescription pads should be printed on distinctive paper so that they can be easily identified. We think that numbered prescription pads represent good practice, since they limit the possibility of misuse, and we would favour their introduction for nurses. They should include the name, professional address, qualifications and telephone number of the prescriber. If a pharmacist had a query about a prescription and could not contact the nurse prescriber, he could find the name of the patient's GP from the patient and contact him.

7.16 Authorised nurse prescribers working outside the NHS should be required to identify themselves by name, professional address and qualifications, and provide a telephone number on all prescriptions.

Arrangements for supply of products

7.17 Our recommendations for nurse prescribing are not intended to alter the current arrangements for dispensing - we envisage that products will be supplied by pharmacists following presentation of a nurse prescription, as they are for doctors' prescriptions (except for those patients for whom doctors both prescribe and dispense - ie "dispensing doctors").

7.18 In some instances, where products are at present supplied by a Health Authority, the issue of a prescription could involve unnecessary costs and delay in treatment, which could result in inconvenience and discomfort to the patient. We believe that Health Authorities should set up practicable systems for the supply of single doses of some products and to provide nurses with their necessary basic supplies. Appendix I lists those products which we consider should be available in this way. In many cases, it will be more cost-effective if such items are supplied by the Health Authority rather than dispensed by community pharmacists.

RECOMMENDATION 20

The UKCC should be asked to continue to identify nurses with district nurse and health visitor qualifications on its register, and to indicate which of those nurses have completed the necessary additional education and training to enable them to prescribe.

RECOMMENDATION 21

The UKCC should make the information on its register of nurse prescribers available to bona fide enquirers.

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RECOMMENDATION 22

It should be the responsibility of each nurse to ensure that her qualifications are registered or recorded with the UKCC. The employing authority, and others involved in agreeing protocols, must make sure that she has done so.

RECOMMENDATION 23

The employing authority should maintain records of authorised nurse prescribers in its employment.

RECOMMENDATION 24

Nurse prescribers should be provided with regular reports on their prescribing patterns.

RECOMMENDATION 25

Prescription pads printed on distinctive paper should be issued to authorised nurse prescribers working in the NHS and include the name, qualifications, professional address and telephone number of the prescriber.

RECOMMENDATION 26

Prescriptions issued by nurses working outside the NHS should carry the name, qualifications, professional address and telephone number of the prescriber.

RECOMMENDATION 27

Health Authorities should set up practicable systems in their own areas for the supply of single doses of some products, where appropriate, and to provide nurses with their necessary basic supplies.

RECOMMENDATION 28

Each authorised nurse prescriber working in the NHS should have an honorary contract with the appropriate FPC.

CHAPTER 8

LEGAL IMPLICATIONS OF NURSE PRESCRIBING

8.1 We recognise that the introduction of nurse prescribing, even in the limited form we are recommending, will require some changes to current legislation. However, as a group advising primarily on professional issues, we did not feel able to provide detailed advice on the legal aspects of our work. Rather than attempting to undertake a task on which Ministers will be guided by their own legal advisers, we have sought simply to identify the major legal implications of our recommendations in order to facilitate planning for implementation.

8.2 We are grateful for the assistance we have received on this aspect of our work from the Department of Health and its legal advisers. We have been told that legislative changes will be necessary in order to provide the administrative framework within which prescribing by nurses can take place. We are advised that an amendment to Section 41 of the NHS Act 1977 will be needed to provide authority for prescriptions written by nurses to be dispensed by pharmacists.

8.3 There will also be implications for the Medicines Act 1968 since we have recommended that district nurses and health visitors should be able to prescribe a limited number of "Prescription Only Medicines" (Chapter 4, paragraphs 4.5 and 4.6). Section 58 of the Medicines Act makes it unlawful for a pharmacist to sell or supply POMs except in accordance with a prescription given by an appropriate practitioner, currently a doctor or dentist. In order to enable nurses to draw up orders for certain POMs to be dispensed by pharmacists, we understand that an exemption order under Section 58 of the Medicines Act will be needed. The order will need to make clear to which medicines the exemption applies.

8.4 We understand that statutory consultation procedures will need to be undertaken if such an exemption order under the Medicines Act is proposed. If Ministers accept our recommendation we suggest that these procedures should be initiated as soon as possible.

8.5 We have also considered the issue of legal liability for nurse prescribers. Our understanding is that this should not give rise to any new principle since, where a nurse undertakes prescribing as part of her normal duties of employment, the Health Authority as her employer is vicariously liable for her actions. Such vicarious liability extends to claims for damages against staff arising from alleged negligence in the performance of official duties. Most nurses obtain additional professional indemnity by means of their membership of a professional organisation or trade union. The Royal College of Nursing produced a helpful policy statement in 1988 titled "Boundaries of Nursing: A Policy Statement" (11) which clarifies many complex issues.

8.6 We recognise that more detailed work will be needed on the legal implications of our recommendations, and we appreciate that it will take time to complete the required consultation procedures and to secure the passage of legislation through Parliament. We hope that Ministers will agree to our recommendations and introduce the necessary legislative changes as soon as possible. Our proposed timetable for implementation is set out in Chapter 10.

RECOMMENDATION 29

The necessary legislative changes should be made as soon as possible in order to enable nurses with district nurse and health visitor qualifications to prescribe all the items in the Nurses' Formulary.

CHAPTER 9

ECONOMIC IMPLICATIONS OF NURSE PRESCRIBING

9.1 The advisory group recognises the importance of costing a proposal for service change so that its introduction can be properly planned and resourced. There is no merit in setting up a service which is inadequately resourced and thus unlikely to be effective.

9.2 We set out in Chapter 1, and confirm here, our guiding principle of concern for what is best for the patient. It is essential, therefore, that the costs and benefits, both financial and non-financial, for patients and carers are also included in any economic appraisal.

9.3 Providing detailed estimates of the costs and benefits of nurse prescribing has proved somewhat problematic. Since there is no such service in existence in this country, nor any comparable services overseas which we could use as models, our costings would have to be based on a variety of assumptions, none of which can at present be tested. We are also particularly anxious that the economic appraisal of nurse prescribing is not dealt with only in terms of financial costs to the NHS, but that it takes account of benefits both to the health service and to individual patients. It is, of course, always easier to put a price on costs than to quantify the benefits, some of which are less amenable to financially-based assessment. We hope that Ministers and the professions will give very serious consideration to the improvements in the quality of care which we firmly believe will come from the introduction of nurse prescribing. The main beneficiaries will be elderly people, vulnerable groups such as the homeless and people with chronically disabling or terminal illness - all regularly designated as "priorities" in successive Government policy statements.

9.4 Although we cannot put figures to all the items, we have identified the main benefits and the main costs which we anticipate from the introduction of nurse prescribing.

ANTICIPATED BENEFITS

Improved quality of care for patients

9.5. We believe that nurse prescribing will result in a significant improvement in the quality of care provided for patients. In "Working for Patients", the Government has reaffirmed its commitment to ensuring that the best quality service is obtained within available resources. It recognises that the patient's primary concern is for a correct diagnosis to be made and for effective treatment to be given. In those clinical areas for which nurses take prime responsibility, we consider that the quality of care provided will inevitably be improved by empowering nurses to prescribe and so play their full part in ensuring that treatment is given effectively and swiftly.

9.6 The benefits enjoyed by each patient will, of course, depend very much on individual circumstances. However, the ability to alter the timing and dosage of medicines should in particular result in better control of symptoms in some groups of patients. It should be particularly beneficial in enabling some terminally ill patients to be maintained in their own homes for a longer period than might otherwise be possible.

9.7 Prescribing by nurses also provides a new opportunity to treat rapidly and effectively minor infections and other conditions suffered by people such as homeless families, travellers, and others who are not registered with a GP or in touch with other traditional services. Health visitors may be the only health professionals in touch with such patients and their ability to assess

and initiate treatment may have a major impact on health outcomes. The provision of general medical services in these circumstances, especially in inner city areas, may present real problems for the FPCs concerned. Whilst initial prescribing by a health visitor or other nurse will not make those problems disappear, or remove any responsibility from FPCs or Health Authorities, it will help to ensure that the benefit of effective treatment for common conditions is not denied to numbers of vulnerable people. It will be essential for the health professionals concerned to act within guidelines to be drawn up by the FPC or Health Authority, acting on advice from the relevant professional representatives.

A service tailored to individual needs

9.8 Nurses working in the community often have a uniquely close knowledge of a patient's full range of health care needs and are well placed to call upon other community services where necessary. We believe that authority to prescribe will enhance the nurse's ability to provide a service responsive to the individual's needs and circumstances. We also expect that patients will be able to obtain the products they need more speedily as a result of nurse prescribing, and that they and their carers will be saved some visits to GPs' surgeries. Again, there may be particular benefits in the care provided for terminally ill people.

Effective use of professional skills

9.9 We consider that all the professionals involved will benefit from a clarification of professional roles within the primary health care team. More effective use will be made of nurses' training and skills, with work being carried out at the most appropriate professional level. This in turn will enable the best use to be made of the time and skills of other professionals

in the team. Allowing the nurse to act on her own initiative in adjusting the timing and dosage of medicines would in addition be generally welcomed as acknowledging the high levels of experience and knowledge of certain groups of nurses. Overall, nurse prescribing will, we believe, lead to a general enhancement of the professional development of nurses.

Direct benefits to NHS

9.10 We would expect that timely and effective treatment of conditions such as varicose ulcers and the more effective management of post-operative wounds should result in shorter stays in hospital and reduce both the numbers of admissions and out-patient Accident and Emergency attendances (particularly in the case of homeless people) and the overall length of treatment. For example, over 150,000 people in the UK suffer from venous ulcers, which are estimated to cost the health service between £300-£600m pa(12). Even a small reduction in overall cost or length of treatment would result in significant savings.

9.11 We also expect that nurse prescribing will minimise wastage since nurses, who tend to have more frequent contact with patients and a greater familiarity with package sizes, can prescribe appropriate quantities of products.

9.12 A further benefit will be the savings in nurse travelling time and mileage which should result if nurses do not have to ask doctors to write prescriptions on their behalf.

ANTICIPATED AREAS OF COST

Direct costs of products prescribed

9.13 In theory, there is no reason to expect increased expenditure on items prescribed by nurses, since the assumption is that patients are receiving adequate care at present. The greater availability and accessibility of some products (eg recently introduced dressings) might result in an increase in expenditure. However, a rise in the total volume of prescribing might be counter-balanced by savings resulting from more appropriate prescribing and reduced duration of treatment. We understand that the net ingredient cost of the items in our illustrative Nurses' Formularly is currently of the order of £140m pa. We do not think it is possible to estimate at present what change in this expenditure might result from nurse prescribing. This will not be clear until nurse prescribing has been thoroughly evaluated.

Administrative costs

(a) NHS

9.14 There is no reason to suppose that the prescribing costs of nurse prescriptions would differ from those of doctors' prescriptions. The only additional cost here, therefore, would attach to any increase in the number of prescriptions dispensed. Depending on the number of nurses who will become prescribers (say 20,000 writing an average of 5 prescriptions a week), this might be about 5 million prescriptions dispensed in a full year. If doctors' prescriptions for the same period were to reduce by 2.5 million because of nurse prescribing, the net administrative cost for dispensing additional prescriptions would be of the order of £3.35m. It might be further reduced by judicious Health Authority supplies.

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9.15 The printing and supply of prescription pads for nurses might involve costs of the order of £24,000 pa. The requirement to price an additional number of prescriptions and provide nurse prescribers with regular prescribing information would result in estimated increased costs for the Prescription Pricing Authority of £300,000 pa.

9.16 If each nurse with authority for initial prescribing were to receive a copy of the Nurses' Formulary, this would cost about £20,000 pa.

(b) UKCC

9.17 The proposal to establish and identify authorised nurse prescribers on the register and to make information from it readily available to bona fide enquirers will lead to some extra administrative and clerical costs. A retrospective charge for the number of enquiries made could be levied on an annual basis to the relevant FPC.

Education and training costs

9.18 There will be an initial cost in training and testing nurses already otherwise qualified to prescribe. If district nurses and health visitors currently in post each required 3 days training, we estimate that training costs would be of the order of £1m. After this "setting up" period, the training costs will be marginal, since the relevant courses already include some pharmacology and therapeutics and could be easily amended to meet new requirements. Although a substantial amount of post-registration education is already provided, courses relevant to prescribing will be needed, which will involve both course costs and the time of participants. It is difficult to tell at this stage whether the requirement would be for additional time for continuing education or for displacement of other continuing education activities.

CHAPTER 10

IMPLEMENTATION, EVALUATION AND MONITORING

10.1 We gave serious consideration to the possibility of establishing pilot studies to provide evidence which might assist in the widespread introduction of nurse prescribing. We were particularly concerned about establishing in more detail the training needs and the economic costs and benefits, as well as testing the feasibility of our proposals. However, our proposals require changes in the law and so it would be impossible to introduce meaningful experimental studies in advance of legislation. We concluded, therefore, that pilot studies would not be feasible.

10.2 We therefore propose that the Government introduces as soon as possible the legislation necessary for the implementation of our recommendations. We realise that this will take time to be approved by Parliament. A clear commitment to such a change will, however, provide the time that is needed for training nurses and developing both the Nurses' Formulary and the administrative arrangements for registration and contracts. There will then be minimal delay between legal changes and service implementation.

10.3 If Ministers support our proposals we hope that arrangements for nurse prescribing could be carried forward within the following timetable:-

	Latest desirable completion date
(i) Consultation with professional and pharmaceutical interests, and with relevant Statutory Committees	September 1990
(ii) Legislation	December 1991
(iii) Implementation	April 1992

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Education and training

10.4 The UKCC and the National Boards for Nursing, Midwifery and Health Visiting will be expected to consider the overall policy for education and training and to consider the competencies, prepare education and training programmes and develop appropriate assessment procedures for those who will be actively engaged in nurse prescribing. This programme should be arranged to fit in with the implementation programme in paragraph 10.3. We recommend that planning for the new education and training programmes should begin as soon as Ministers indicate their general support for the principles set out in this report.

Identification

10.5 The UKCC should be asked to have in place arrangements for verifying authorised nurse prescribers by April 1992.

Appeals and reviews procedures

10.6 The Department of Health will need to establish appeals and reviews procedures relating to products in the Nurses' Formulary.

Management issues

10.7 The financial allocations to Regional Health Authorities and to FPCs will need to take into account the requirements of nurse prescribing from the beginning of the financial year 1992-3. Central and local monitoring arrangements, including systems for providing prescribing information to nurse prescribers, will need to be established by the Prescription Pricing Authority.

RECOMMENDATION 30

An appropriate timetable for the introduction of nurse prescribing should be set nationally in consultation with potential nurse prescribers and taking account of education and training requirements. The legislative and education/training timetables should be co-ordinated. The aim should be to introduce nurse prescribing on 1 April 1992.

Evaluation

10.8 It is essential that a service change of this kind is evaluated, to see that the objectives have been achieved, to assess the costs and benefits, and to provide information for future modifications to the service. We hope that the Department of Health will commission an evaluation study from a suitably experienced research department, which will assess the service on a broad base.

RECOMMENDATION 31

An evaluation programme should be established before the implementation of nurse prescribing so that some relevant baseline information can be gathered.

RECOMMENDATION 32

The evaluation study should include an assessment of the views of patients, relatives, nurses and other members of primary health care teams, as well as a full economic appraisal. Where possible, health outcomes should be measured.

10.9 Systems should also be introduced for the monitoring of nurse prescribing so that, in addition to regular prescribing feedback to nurses themselves, information is available to professional bodies, managers and the Department of Health on the number of nurses actively prescribing, the range and cost of the products used, and the characteristics of the patients for whom the nurses prescribe.

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Mr J Newton
DH Family Practitioner Services Division

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DH Medical Division

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SECRETARIAT

Ms A F Gross (succeeding Mr A F Mummery)
Secretary

Mrs S Dewar (Professional representative, District Nurse
on secondment from Chichester Health Authority)

Mr P W Wiles

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GLOSSARY

Definitions for the purpose of this report

Community nursing staff	-	the wide range of nurses (including district nurses, specialist nurses, midwives and health visitors, but excluding nursing auxiliaries) employed by a District Health Authority to provide nursing services to patients needing care outside hospital.
First-level nurse	-	a nurse whose name is on the First-level part of the UKCC Register ie RGN, RMN, RNMH, RSCN.
District nurse	-	a Registered General Nurse whose post-registration education and training in district nursing enables her to give skilled nursing care to patients in the community. She is the leader of the district nursing team.
Health visitor	-	a Registered General Nurse whose post-registration education and training in health visiting equips her especially to promote health and prevent disease.
Paediatric community nurse	-	a Registered Sick Children's Nurse who has also obtained post-registration education and training in district nursing enabling her to give skilled nursing care to sick children in the community.
Practice nurse	-	a nurse employed by a GP as a member of his practice team.
Specialist nurses	-	nurses undertaking specialised clinical work in the community. We have included under this heading continence advisers, stoma care nurses, paediatric clinical nurses, diabetic liaison nurses and nurses who specialise in caring for the terminally ill (including MacMillan and Marie Curie nurses).
School nurse	-	a RGN or RSCN who has completed the current National Board approved School Nurse course which is recorded on the register maintained by the UKCC.

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Community pharmacist	-	a pharmacist providing Part II pharmaceutical services for the NHS from registered premises in the community.
Community services pharmacist	-	Community services pharmacists are pharmacists based in a Health Authority with responsibility for the provision of pharmaceutical services to the community health service and other priority care groups within the Health Authority's remit.
General practitioner (GP)	-	a community-based doctor trained in general medicine who takes the lead in treating most forms of illness. Often known as the "family doctor", he is usually a patient's main point of contact with the medical profession, exercising his judgement as to whether a case requires more specialised advice or treatment.
Primary health care team	-	group of health professionals dealing with people outside hospital. The core team includes GP, district nurse, practice nurse, midwife, health visitor. The extended team may also include community psychiatric nurses, community mental handicap nurses and social care professionals. A few primary health care teams also include a pharmacist.
Prescribe	-	authorisation to enable a patient to obtain a medicine, appliance or other remedy.
Supply	-	to make available (sometimes through the community health services) medicines, appliances or other remedies.
Order	-	an authority to obtain medicines and other items needed for the standard management of certain categories of patients within a group protocol
Medicine	-	any of the medicines, medicated dressings or other medicated products included in the Drug Tariff, other than appliances and chemical reagents.
Pharmacy medicines (P medicines)	-	medicines which can be sold or supplied only at a registered pharmacy by or

		under the supervision of a pharmacist (ie. all medicinal products other than those designated as General Sales List products or Prescription Only Medicines by an Order under the Medicines Act 1968).
Prescription Only Medicines (POMs)	-	medicinal products which may only be sold or supplied against a doctor's (or dentist's) prescription. (Such products are listed in Schedule 1(1) to the Medicines (Products other than Veterinary Drugs)(Prescription Only) Order 1983 - SI 1983/1212 - as amended).
General Sales List products	-	medicinal products which can be obtained over the counter (subject to certain conditions).
Group protocol	-	a locally agreed statement defining the standard management of certain categories of patients which has been agreed by all relevant health professionals. The statement will include arrangements for initial assessment and review.
Patient-specific protocol	-	a written statement defining the management of a named patient which has been agreed by the doctor and nurse responsible for the patient, and by any other appropriate health professionals. The protocol will set out the range within which the timing and dosage of medicines can be altered and the clinical criteria on which decisions to alter timing and dosage should be based.

GLOSSARY OF QUALIFICATIONS

RGN	Registered General Nurse
RMN	Registered Mental Nurse
RNMH	Registered Nurse - Mental Handicap
RSCN	Registered Sick Children's Nurse
DN	District Nurse

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RHV Registered Health Visitor

CPN Community Psychiatric Nurse

CNMH Community Nurse - Mental Handicap

FPN Family Planning Nurse

PWT Practical Work Teacher

FWT Field Work Teacher

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ORGANISATIONS AND INDIVIDUALS SUBMITTING WRITTEN AND ORAL EVIDENCE OR PARTICIPATING IN INFORMAL DISCUSSIONS

Written evidence

ASSOCIATION OF CONTINENCE ADVISORS
BRITISH GAS MEDICAL COMMITTEE
COLLEGE OF PHARMACY PRACTICE
FACULTY OF COMMUNITY MEDICINE
FACULTY OF OCCUPATIONAL MEDICINE
GENERAL MEDICAL SERVICES COMMITTEE
GUILD OF HOSPITAL PHARMACISTS
HEALTH VISITORS' ASSOCIATION
JOINT CONSULTANTS COMMITTEE
MEDICAL ADVISORY COMMITTEE, UK OFFSHORE OPERATORS' ASSOCIATION
NATIONAL PHARMACEUTICAL ASSOCIATION
PHARMACEUTICAL SERVICES NEGOTIATING COMMITTEE
PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND
ROYAL COLLEGE OF NURSING
ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS
ROYAL COLLEGE OF PHYSICIANS
ROYAL COLLEGE OF SURGEONS OF ENGLAND
ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

Oral evidence

DR JOHN W CHISHOLM, General Medical Services Committee
MR DEREK J DEAN, Royal College of Nursing
MRS AINNA FAWCETT-HENESY, Royal College of Nursing
MR W B RHODES, Royal Pharmaceutical Society of Great Britain

Informal discussions

Community nursing staff in Bath, Chichester, East Cumbria and Wandsworth Health Authorities

Educationalists/community nursing staff in:
- Manchester Polytechnic
- Southwark Polytechnic, London
- Queen Alexandra Hospital, Portsmouth
- Royal Marsden Hospital
- Mawbrey Brough Health Centre, London
- London Hospital
- St Martin's Hospital, Bath
- Plymouth Polytechnic
- English National Board for Nursing, Midwifery and Health Visiting
- United Kingdom Central Council for Nursing Midwifery and Health Visiting

Occupational health representatives of British Airways and the English National Board for Nursing, Midwifery and Health Visiting

NHS PRIMARY HEALTH CARE NURSING STAFF IN POST IN UNITED KINGDOM AT 30 SEPTEMBER 1988

	NUMBERS (HEADCOUNT) (1)
Health Visitors (2) (4)	14,790
District Nurses (3)	13,170
Community Psychiatric Nurses	3,420
Community Mental Handicap Nurses	1,610
School Health Nurses (4)	4,410
Family Planning Nurses	2,150
Stoma Care Nurses	90

SOURCE: DEPARTMENT OF HEALTH (SMI3) ANNUAL CENSUS OF NHS NON-MEDICAL MANPOWER, WELSH OFFICE, SCOTTISH HEALTH SERVICE COMMON SERVICES AGENCY AND NORTHERN IRELAND DEPARTMENT OF HEALTH AND SOCIAL SERVICES.

NOTES:
(1) Figures are numbers (headcount) rounded to nearest ten (10).

(2) Includes Health Visitors, HV TB Visitors, HV Field Work Teachers, Triple Posts, Bank HVs and School HVs.

(3) Includes District Nurses, District Nurse Practical Work Teachers, Dual Posts and Bank District Nurses.

(4) School Health Visitors are also included in total Health Visitors (some 100 number (headcount)).

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ILLUSTRATIVE NURSES' FORMULARY

The Formulary is based on the British National Formulary (BNF) classification, to which the headings and sub-headings refer. Unless otherwise stated all preparations of the drugs listed in this Formulary which appear in the relevant entry in the BNF should be available for nurse prescribing.

GASTRO-INTESTINAL SYSTEM

Laxatives:

- Isphagula husk granules
- Sterculia
- Bisacodyl suppositories
- Docusate Sodium (rectal/oral)
- Glycerol suppositories
- Lactulose
- Phosphates enema
- Sodium citrate enema

Stoma care products:

- Adhesives
- Adhesive removers
- Deodorants
- Skin protectives, fillers and cleansers

CENTRAL NERVOUS SYSTEM

Analgesics-non-opioid:

- Aspirin
- Paracetamol

INFECTIONS

Anthelmintics:

- Piperazine

OBSTETRIC, GYNAECOLOGICAL AND URINARY TRACT DISORDERS

Bladder instillations:

- Preparations for maintenance of indwelling catheters

EAR, NOSE AND OROPHARYNX

Removal of ear wax:

- Sodium Bicarbonate ear drops

Oropharyngeal anti-infective drugs:

- Nystatin oral suspension
- Nystatin pastilles

Mouthwashes, gargles:
Hexetidine
Povidone-Iodine
Thymol

SKIN

Emollient and barrier preparations:
Emollient and barrier creams
(all entries under this heading)
Emollient bath additives
(all entries under this heading)

Local anaesthetic and antipruritic preparations:
Calamine

Antifungal preparations:
Clotrimoxazole

Preparations for boils:
Magnesium Sulphate paste

Skin disinfecting and cleansing agents:
Aqueous solution of 10% providone-iodine
Silver Nitrate
Sodium Chloride

Desloughing agents:
Iodosorb
Variclene
Varidase Topical

Parasiticidal preparations:
(All entries under this heading)

ANAESTHESIA

Local anaesthesia:
Lignocaine Hydrochloride

Additionally we believe the vast majority of the items in parts IX A, B, C and R of the Drug Tariff should be available, subject to the following exceptions in part IX A:

- contraceptive devices, apart from fertility thermometers;

- gauze dressings (impregnated), apart from paraffin gauze dressing and BP sterile (because it is not clinically appropriate for nurses to prescribe them);

- hydrocortisone and silicone bandage (a POM product - again, because it is not clinically appropriate for nurses to prescribe this).

INFORMATION ON EDUCATION AND TRAINING OF NURSES WORKING IN THE COMMUNITY

DESIGNATION	REGISTERABLE/RECORDABLE QUALIFICATION REQUIRED FOR PRACTICE	NON-MANDATORY COURSES AVAILABLE	LENGTH OF COURSE	METHODS OF ASSESSMENT	CAPACITY OF CURRENT COURSES TO ADAPT TO RECOMMENDATIONS IN REPORT
DISTRICT NURSE	RGN DN CERTIFICATE	-	ACADEMIC YEAR	CONTINUOUS ASSESSMENT BY TUTORS, PWT AND ASSESSORS	ADEQUATE WITHOUT LENGTHENING
HEALTH VISITOR	RGN RHV	-	CALENDAR YEAR	CONTINUOUS ASSESSMENT BY TUTORS, FWT AND SUPERVISORS	ADEQUATE WITHOUT LENGTHENING
PAEDIATRIC COMMUNITY NURSE	RSCN DN CERTIFICATE	-	ACADEMIC YEAR	CONTINUOUS ASSESSMENT BY TUTORS, PWT AND ASSESSORS	ADEQUATE WITHOUT LENGTHENING
COMMUNITY PSYCHIATRIC NURSE	RMN	CPN CERTIFICATE (RECORDABLE QUALIFICATION)	ACADEMIC YEAR	CONTINUOUS ASSESSMENT BY TUTORS AND ASSESSORS	ADEQUATE WITHOUT LENGTHENING
COMMUNITY NURSE/MENTAL HANDICAP	RNMH	CNMH CERTIFICATE (RECORDABLE QUALIFICATION)	ACADEMIC YEAR	CONTINUOUS ASSESSMENT BY TUTORS AND ASSESSORS	ADEQUATE WITHOUT LENGTHENING
SPECIALIST NURSE - DRUG AND ALCOHOL DEPENDENCY	RMN/RGN	DRUG AND ALCOHOL DEPENDENCY NURSING	ACADEMIC YEAR	CONTINUOUS ASSESSMENT BY TUTOR AND ASSESSOR	ADEQUATE WITHOUT LENGTHENING

INFORMATION ON EDUCATION AND TRAINING OF NURSES WORKING IN THE COMMUNITY

DESIGNATION	REGISTERABLE/RECORDABLE QUALIFICATION REQUIRED FOR PRACTICE	NON-MANDATORY COURSES AVAILABLE	LENGTH OF COURSE	METHODS OF ASSESSMENT	CAPACITY OF CURRENT COURSES TO ADAPT TO RECOMMENDATIONS IN REPORT
SCHOOL NURSE	RGN/ RSCN	SCHOOL NURSE CERTIFICATE (RECORDABLE QUALIFICATION)	3 MONTHS	CONTINUOUS ASSESSMENT BY TUTORS	ADEQUATE WITHOUT LENGTHENING
SPECIALIST NURSE TERMINAL CARE	RGN	CARE OF THE DYING PATIENT AND THEIR FAMILY	8 WEEKS	CONTINUOUS ASSESSMENT BY TUTORS	ADEQUATE WITHOUT LENGTHENING
STOMA CARE NURSE	RGN	STOMA CARE (RECORDABLE QUALIFICATION)	8 - 9 WEEKS	CONTINUOUS ASSESSMENT BY TUTORS	ADEQUATE WITHOUT LENGTHENING
CONTINENCE ADVISER	RGN	COURSES ON PROMOTION OF CONTINENCE AND MANAGEMENT OF INCONTINENCE	12 DAYS	COURSE-PROJECT	COURSE WOULD REQUIRE LENGTHENING
SPECIALIST NURSE DIABETIC LIAISON	RGN	DIABETIC	4 DAYS	NO FORMAL ASSESSMENT	COURSE WOULD REQUIRE LENGTHENING
PRACTICE NURSE	RGN	PRACTICE NURSE	10 DAYS	NO FORMAL ASSESSMENT	-
FAMILY PLANNING NURSE	RGN	FAMILY PLANNING	20 DAYS INCLUDING THEORY AND PRACTICE	CONTINUOUS ASSESSMENT BY COURSE TUTORS AND INSTRUCTING NURSES	-

GUIDELINES FOR GOOD PRACTICE IN COMMUNICATIONS

1. As far as practicable, arrangements for sharing and communicating all relevant information should be incorporated in locally agreed statements of good practice. Such statements may conveniently form part of any joint agreement relating to the work of the primary health care team.

2. Any statement should identify all professionals involved (or likely to be involved) in prescribing for a particular patient and ensure that they are appropriately qualified and fully aware of each other's actions and decisions.

3. A list of prescribers should form part of the GP's records for each patient and, where practicable, of any records held by the patient.

4. The records should also include details of each item prescribed, and identify the prescriber.

5. The records should be accessible to all listed prescribers and to any nurse preparing to visit the patient for the first time.

6. The records should also be available to pharmacists so that they may, whenever necessary, obtain prompt clarification from prescribers.

7. The manager responsible for organising community nursing services in a particular area should aim to reach agreement with each general medical practice in that area on the procedures for maintaining records and making them accessible.

GUIDELINES FOR THE PRODUCTION OF PROTOCOLS

Group protocols: A 'group protocol' is a locally agreed statement defining the standard management of certain categories of patients which has been agreed by all relevant health professionals.

1. The decision to establish protocols for the management of certain categories of patients and for the supply of medicines by nurses to those patients should be taken by the doctors and nurses responsible for the relevant clinical service.

2. The clinical staff involved in establishing the protocol should be satisfied that the nurses supplying within the terms of the protocol are suitably trained and experienced.

3. The protocol must have full regard to current guidelines for the safe and secure handling of medicines.

4. The protocol must be written.

5. A group protocol must clearly state:-

   a. the clinical information and measurements required for each patient;

   b. the limits of the parameters in (a) within which a patient may be managed within the protocol;

   c. the indications for review of the decision to manage within the protocol;

   d. the range of medicines (including frequency and dosages) which can be supplied within the protocol;

   e. the arrangements for follow-up (including clinical observations required and arrangements to vary timing and dosage);

   f. the acceptable duration of treatment within the protocol;

   g. the arrangements for recording treatment;

   h. the arrangements for communication with the appropriate medical practitioner (normally the GP);

   i. the indications for referral to a medical practitioner.

Patient-specific protocols: A patient-specific protocol is a written statement defining the management of a named patient which has been agreed by the doctor and nurse responsible for the patient, and by any other appropriate health professionals. The protocol will set out the range within which the timing and dosage of medicines can be altered, and the clinical criteria on which decisions to alter timing and dosage should be based.

1. The decision to establish a protocol for varying the timing and dosage of medicines prescribed for particular patients must be taken jointly - and in co-operation with the individual patient - by the doctors and nurses directly concerned and should include the pharmacist when appropriate.

2. All parties must be sure that the nurses involved are adequately trained and experienced.

3. All protocols must be written, available to relevant professionals and included in the patient's medical records.

4. Agreement to work within patient-specific protocols implies:-

   a. agreement by doctors that nurses should have access to all essential information about the medical condition of the patient and the treatment he/she is receiving;

   b. agreed procedures to ensure such access;

   c. the obligation of nurses to record their actions in detail, and in a manner consistent with a locally agreed format;

   d. compliance with locally agreed Health Authority policies on the administration of medicines.

5. Each patient-specific protocol must clearly state:-

   a. the range within which the dosage of specified medicines may be altered;

   b. the range within which the time-intervals between doses of specified medicines may be varied;

   c. the clinical observations or measurements upon which decisions to change timing and dosage will be made;

   d. the indications for referral back to the doctor who has clinical responsibility for the patient;

   e. procedures to be followed in an emergency;

   f. the frequency with which the protocol will be reviewed by the doctor, nurse and other professionals involved.

6. Protocols must have full regard to current guidelines for the safe and secure handling of medicines.

BASIC NURSING SUPPLIES

The advisory group considers that the following items, currently available on prescription, could be more conveniently supplied to district nurses by their employing authorities:

Sterile dressing pack containing: sterile field
gauze swabs
wool balls
galipot
forceps

Sterile dressing pads in various sizes: 10cm x 10cm, 10cm x 20cm, 20cm x 20cm.

Sterile gauze swabs in packs of 5.

Sterile wool balls in packs of 5.

Sterile packs containing the items needed for catheter change/initial insertions.

Sterile packs containing the items needed to obtain a mid-stream specimen of urine.

Sterile packs containing the items needed for oral hygiene.

Sterile packs containing the items needed for suture removal.

Sterile eye pads.

Sterile ribbon gauze in various widths and lengths.

Sterile forceps.

Sterile scissors.

Sterile probes.

Small sachets of normal saline.

Small sachets of cleansing agent in accordance with locally agreed control of infection policies.

Sterile rectal tubes.

It would, in addition, be useful if employing authorities supplied the following items on a stop-gap basis to cover needs while prescriptions are filled:

Sterile catheters; self-retaining and non self-retaining
Bandages
Tape
Tubigauze

Single-dose sachets of paracetamol

The advisory group recommends easy access to CSSD, so that infrequently used sizes of dressings can be obtained as required.