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Non-Medical Prescribing Policy (v2)

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NON-MEDICAL PRESCRIBING POLICY

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CONTENTS

SCOPE

This policy sets out the administrative and procedural steps needed to enable non-medical practitioners, who have successfully completed V100, V150 or V300 training, to prescribe on the Isle of Man. It also provides advice on good practice for Independent Non-medical Prescribers, Supplementary Prescribers and their Independent Prescriber partner (doctor or dentist).

Part 1 of the policy refers to Independent prescribing; however, the standards described in sections 3 – 10 are applicable to both independent and supplementary prescribing.

Legislation currently allows the following, suitably qualified, practitioners to prescribe on the IOM:

- Registered Nurses, Midwives and Health Visitors.
- Pharmacists.
- Physiotherapists.
- Therapeutic radiographers.
- Optometrists.
- Podiatrists.
- Paramedics.

From herein, the title Non-medical Prescriber (NMP) will refer to all the above-listed professions (unless otherwise indicated); and, as such, they are guided, and bound, by the contents of this policy.

Related Policies/Guidance

This policy should be read in conjunction with:

- DHSC All Island Medicines Policy (2019).
- Royal Pharmaceutical Society (July 2016): A Competency for Framework for all Prescribers. Available at: https://www.rpharms.com/resources/frameworks/prescribers-competency-framework

DEFINITIONS

Community-Based Nurse Prescriber (CBNP)

This term is used throughout the policy to describe Health Visitors, District Nurses, Specialist/Long-term Condition Nurses, Practice Nurses, Community Mental Health Nurses, and those working in Prison Healthcare or Ramsey and District Cottage Hospital. It also refers to nurses employed by the Hospice or private nursing homes.

Non-Medical Prescriber (NMP)

NMP is the generic term for nurses and allied health professionals who have successfully completed a recognised training course in Independent or Supplementary prescribing.

Independent Prescribing

Independent prescribing is described as being where:

The prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as for prescribing (where necessary) and the appropriateness of any prescription (DOH 2006).

Community Practitioner Nurse Prescriber (CPNP)

These are District Nurses, Health Visitors and other registered nurses working in community settings who have successfully completed a V100 or V150 prescribing course. As such, they are qualified to prescribe from the Nurse Prescribers Formulary for Community Practitioners. The formulary contains appliances, dressings, and a limited number of prescription (or general sales list) drugs, which the nurse may prescribe when indicated. The appropriate training for prescribing from this Formulary is incorporated into the basic training for Specialist Community Public Health Nurses and the Specialist Practitioner Qualification; or can be accessed via Keyll Darree for registered nurses working within community settings.

Independent Prescriber (IP)

Independent prescribers are registered practitioners who have successfully completed a V300 Non-medical Prescribing course. They are able to prescribe medicines and products contained within the British National Formulary (BNF)*, including unlicensed medicines and controlled drugs, so long as they are:

- Prescribing within their clinical competence and area of expertise.
- Operating within their agreed written contract (see Appendix A).

**See Part 1(1) and section 2.2 for restrictions.*

Supplementary Prescriber (SP)

Supplementary prescribing is defined as being:

A voluntary partnership between an Independent Prescriber (a Doctor or Dentist) and a Supplementary Prescriber; to implement an agreed patient specific Clinical Management Plan with the patient's agreement (DOH 2006).

There are no legal restrictions on the clinical conditions that may be treated under supplementary prescribing, although supplementary prescribing will usually be used for the management of chronic medical conditions and health needs.

There is no specific formulary or list of medicines for supplementary prescribing, provided medicines are prescribable by a Doctor or Dentist at NHS expense; and that they are referred to in the patient's Clinical Management Plan.

Training for supplementary prescribing is combined with independent prescribing training.

Patient Group Directions (PGD)

A PGD is a written direction - signed by a doctor or dentist - allowing health professionals to supply and/or administer a licensed prescription-only medicine. PGDs and non-medical prescribing differ significantly, in that:

- An Independent Prescriber is accountable and responsible for the assessment, diagnosis and prescribing decisions made within the remit of the prescribing formulary for each individual patient/client seen.

- A PGD is defined as a written direction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. It is not a form of prescribing and, whilst health professionals have to undertake local training, there is no accredited training that health professionals must undertake before supplying or administering medicines in this way.

- PGDs are developed in situations where it may not be feasible to have separate prescriptions written for each individual patient/client and where it is possible to follow clearly defined guidelines to assist the assessment and diagnosis of a condition and where availability to supply or administration of treatment enhances care provision.

- The majority of clinical care should still be provided on an individual, patient-specific basis. PGDs should be reserved for those limited situations where there is an advantage for patient care without compromising patient safety.

- PGDs may only be used by named individuals.

- PGDs should be drawn up by a multidisciplinary group and must be signed by a Medical Practitioner, a pharmacist, the lead of the profession involved, the Chair of the appropriate Prescribing Committee and the Clinical Governance Committees.

Unlicensed and Off-label Medicine

- An unlicensed medicine is one with no Marketing Authorisation for any formulation or indication in the UK.

- Off-label refers to the use of a licensed medicine outside the terms of its Marketing Authorisation.

PART 1: INDEPENDENT PRESCRIBING

1. LEGAL ENTITLEMENT TO PRESCRIBE

1.1. The following groups of professionals are legally entitled to prescribe medication as listed below *(NICE/BNF 2021)*:

1.1.1. Health Visitors, District Nurses, Practice Nurses and Community registered nurses with the V100 or V150 may only prescribe from the items listed in the Nurse Prescribers' Formulary.

1.1.2. Nurse Independent Prescribers (formerly known as Extended Formulary Nurse Prescribers) are able to prescribe any medicine for any medical condition but must work within their own level of professional competence and expertise. This includes "off-label" medicines subject to accepted clinical good practice.

Nurse Independent Prescribers are able to prescribe, administer, and give directions for the administration of Schedule 2, 3, 4, and 5 Controlled Drugs. This extends to diamorphine hydrochloride, dipipanone, or cocaine for treating organic disease or injury, but **not** for treating addiction.

1.1.3. Pharmacist Independent Prescribers can prescribe any medicine for any medical condition. This includes unlicensed medicines, subject to accepted clinical good practice.

They are also able to prescribe, administer, and give directions for the administration of Schedule 2, 3, 4, and 5 Controlled Drugs. This extends to diamorphine hydrochloride, dipipanone, or cocaine for treating organic disease or injury, but **not** for treating addiction.

Pharmacist Independent Prescribers must work within their own level of professional competence and expertise.

1.1.4. Physiotherapist Independent Prescribers can prescribe any medicine for any medical condition. This includes "off-label" medicines subject to accepted clinical good practice. They are also allowed to prescribe the following Controlled Drugs: oral or injectable morphine, transdermal fentanyl and oral diazepam, dihydrocodeine tartrate, lorazepam, oxycodone hydrochloride or temazepam.

Physiotherapist Independent Prescribers must work within their own level of professional competence and expertise.

1.1.5. Therapeutic Radiographer Independent Prescribers can prescribe any medicine for any medical condition. This includes "off-label" medicines subject to accepted clinical good practice. Prescribing of Controlled Drugs is subject to legislative changes. Therapeutic Radiographer Independent Prescribers must work within their own level of professional competence and expertise.

1.1.6. Optometrist Independent Prescribers can prescribe any licensed medicine for ocular conditions affecting the eye and the tissues surrounding the eye, except Controlled Drugs or medicines for parenteral administration. Optometrist Independent Prescribers must work within their own level of professional competence and expertise.

1.1.7. Podiatrist Independent Prescribers can prescribe any medicine for any medical condition. This includes "off-label" medicines subject to accepted clinical good practice. They are also allowed to prescribe the following Controlled Drugs for oral administration: diazepam, dihydrocodeine tartrate, lorazepam and temazepam.

Podiatrist Independent Prescribers must work within their own level of professional competence and expertise.

1.1.8. Paramedic Independent Prescribers can prescribe any medicine for any medical condition. This includes "off-label" medicines subject to accepted clinical good practice. Prescribing of Controlled Drugs is subject to legislative changes. Paramedic Independent Prescribers must work within their own level of professional competence and expertise.

1.2. Each practitioner must have their prescribing status recorded with their professional regulatory body and must complete a Notification of Newly Qualified Non-medical Prescriber form (see Appendix B).

1.3. This form should also be used to notify the NMP Lead of any change in circumstances.

1.4. The criteria for undertaking NMP training can be found in Appendix C.

2. PRESCRIBING OF CONTROLLED DRUGS BY NON-MEDICAL PRESCRIBERS

2.1. Legal Framework

2.1.1. The Isle of Man Misuse of Drugs Act 1976 allows the United Kingdom (UK) Misuse of Drugs Regulations to be applied to the Isle of Man with the approval of Tynwald.

2.1.2. The UK Misuse of Drugs Regulations 2001 are applied to the Island from 1 December 2013; therefore, the same prescribing rules for non-medical prescribers regarding controlled drugs will apply to the Island as they do in the UK.

2.1.3. Regulations surrounding the prescribing of controlled drugs differ for each profession. Prior to prescribing any CD, it is the NMP's professional duty to check which drugs they are permitted to prescribe. Further information is available via the following link:

https://bnf.nice.org.uk/guidance/non-medical-prescribing.html

2.2. NMP Practitioners

Practitioners are able to prescribe CDs as, listed in schedules 2-5, so long as they are competent to do so (see 2.1.3 regarding limitations). **They cannot, however, prescribe diamorphine, cocaine or dipipanone for the treatment of addiction (although they may prescribe these drugs to treat organic disease or injury).**

Legislation surrounding authority to possess, supply, and offer to supply, controlled drugs (CDs) differs between nurses and pharmacists (see the Misuse of Drugs Regulations).

Podiatrists and physiotherapists are only able to prescribe and administer (the specified CDs). These professions cannot possess, stock or supply.

2.3. Mixing of Medicines that Include Controlled Drugs

Pharmacists already have authority to mix any drugs in schedules 2-5. Independent prescribers (as well as supplementary prescribers, acting in accordance with the terms of a clinical management plan for an individual patient) are authorised to mix any drugs listed in schedules 2-5, prior to administration, in accordance with the profession's CD regulations (see section 2.13). Persons following the written directions of an independent prescriber or, a supplementary prescriber (when acting in accordance with the terms of a clinical management plan) are authorised to mix drugs listed in schedules 2-5.

2.4. Patient Group Directions

Patient Group Directions (PGD) are not a form of prescribing, but these amendments to the Misuse of Drugs Regulations also make changes to the authorities that nurses and pharmacists possess when acting in accordance with a PGD. Nurses and pharmacists working under a PGD are now authorised to supply, or offer to supply, diamorphine and morphine where administration of such drugs is required for the immediate and necessary treatment of sick or injured persons (excluding the treatment of addiction). This removes the restrictions whereby a nurse could only supply diamorphine under a PGD for the treatment of cardiac pain in patients admitted to a coronary care unit or an accident and emergency department of a hospital. The existing authorities for registered health professionals working in accordance with a PGD to supply and/or administer all drugs in schedules 4 and 5 of the 2001 regulations remain.

Note: The changes relating to prescribing and mixing of CDs by nurse and pharmacist independent prescribers also apply to midwives who are registered as nurse independent prescribers. The amendments relating to PGDs also apply to midwives who are registered nurses.

For Supplementary Prescribing of controlled drugs see Point 11.1, Part 2 bullet point 5.

3. NOTIFICATION OF QUALIFICATION TO PRESCRIBE

3.1. Individuals who successfully complete a prescribing course should notify their relevant professional body.

3.2. Newly qualified Non-Medical prescribers will be required to complete relevant paperwork for the Non-Medical Prescribing Lead.

3.3. New prescribers must not prescribe until all the necessary agreements and safeguards are in place.

4. KEEPING REGISTERS OF NON-MEDICAL PRESCRIBERS

4.1. In order that pharmacists are able to check whether a non-medical prescription handed in for dispensing is bona fide:

4.1.1. A copy of each prescriber's signature will be held by the Community Nursing Department / Pharmacy Department at Noble's Hospital and prescribers must provide specimen signatures to pharmacists at their request.

4.1.2. Those Managers responsible for non-medical prescribers will also hold a copy of each prescriber's signature.

4.1.3. Non-medical prescribers are reminded that pharmacists have legal and ethical obligations which mean they may need to contact prescribers, sometimes urgently, to confirm an aspect of the prescription, return it for amendment or refrain from dispensing it, (for example if the prescription appears unsafe or contains items which a prescriber is not permitted to prescribe).

5. ON-GOING EDUCATION, CLINICAL SUPERVISION, AND CLINICAL GOVERNANCE

5.1. Prescribing must take place within a Framework of Clinical Governance.

5.2. Prescribers must keep up to date with best practice in the management of conditions for which they may prescribe and of the use of the drugs, dressings, and appliances they use.

5.3. Prescribers are expected to utilise clinical supervision and peer review and support to enhance their practice in this area.

6. THE PRESCRIPTION FORM (Independent and Supplementary Prescribing).

Prescribers will use approved prescription forms appropriate to their clinical practice (prescriptions which require dispensing at community pharmacies must be written on an HS10).

6.1. Obtaining Stocks of Prescription Forms

6.1.1. Prescription Forms for non-medical prescribers working within the community will arrive, ready personalised, with the professional's details and are supplied by the Community Nursing Department, Crookall House.

Practitioners using an electronic medical records system (such as EMIS) will have access to printed prescription sheets which will require a signature only.

6.1.2. Standardised prescription pads, which are serial numbered, will be supplied by the Pharmacy Department at Noble's Hospital for Secondary Care prescribers.

6.2. How to Complete the Prescription Form

6.2.1. The prescriber must complete all the details on the prescription form by writing clearly and legibly using an indelible black pen.

The details required are:

- The patient's surname, first name, full address, date of birth and age if a child is under twelve.

  The only exception to this rule involves patients attending GUM clinic, where patient identification numbers are used.

- The generic name, quantity, and strength, of the prescribed items; along with dosage and frequency. To avoid waste, the quantity prescribed must be appropriate to the patient's treatment needs (although some medicines are only available in original packs or special containers).

6.2.2. The names of medicines should be written in full using the British approved name (generic title), as specified in the BNF. The only exception to this rule is for the prescribing of dressings and appliances or medication included in the current Manx Care publication of drugs recommended for branded prescribing (available via the Pharmaceutical Advisor).

6.2.3. Directions must be written in English. Latin abbreviations, as listed in the BNF, are acceptable.

6.2.4. The prescriber's signature, and date, must be present.

6.2.5. Where there is more than one item on a form, a line must be inserted between each item for clarity.

6.2.6. Unused space in the prescription area of the form must be blocked out with a diagonal line.

6.2.7. Computer generated prescriptions and approved hospital medicine charts are acceptable.

Further guidance on prescription writing is available in the BNF.

6.3. **Security and safe handling of prescription forms:**

6.3.1. The security of prescription forms is the responsibility of the prescriber (see Appendix D[1]). It is advisable to hold only minimal stocks of the forms. The prescriber must keep records of the serial numbers of prescriptions issued to them. The Community Nursing Department (for all Primary Care Prescribers) or the Pharmacy Department at Noble's Hospital will also record the serial numbers of the prescriptions issued.

6.3.2. In the event of a loss or suspected theft, the prescriber must report this immediately to the Pharmaceutical Advisor or the pharmacy department at Noble's Hospital and their line manager (see Appendix D[2]). Practice nurses must also report the loss or suspected theft to the G.P. The Pharmaceutical Advisor will notify the local pharmacists and decide upon any necessary action to minimise the abuse of the forms.

6.3.3. Blank prescription forms must not be pre-signed to prevent the risk of misuse should they fall into the wrong hands. The prescription form must only be produced when needed and never left unattended. Prescription forms must be stored in a locked drawer. When out visiting, it is essential for prescribers to keep prescription pads secure, they should **never** be left in the car.

6.3.4. Prescribers who leave the service must ensure prescription pads are handed to the Community Nursing Department / Noble's Hospital Pharmacy Department, and their line manager informed of the same, before departing. Individualised prescription pads will be destroyed.

6.3.5. Practitioners using an electronic medical records system should be mindful of the fact that there will be blank prescription sheets in their printer. The area must, therefore, be secured when no staff are present.

7. GOOD PRACTICE, ETHICS, AND ISSUES COMMON TO ALL PRESCRIBERS

7.1. **Responsibility for prescribing decisions**

7.1.1. Qualified prescribers must not issue prescriptions on behalf of anyone else. A prescriber can only issue a prescription for a patient whom she/he has assessed and must only write prescriptions on the prescription pad supplied.

7.1.2. A prescription should generally provide treatment for no more than one calendar month. However, prescribers will need to ensure that the prescription is cost effective and meets the clinical needs of the patient. Patients requiring long term treatment should have their needs continually assessed and prescriptions issued should reflect assessed need. Only sufficient supplies should be prescribed to enable the fulfilment of the care plan, normally up to the re-evaluation date.

7.1.3. In the absence of the patient's original prescriber, another prescriber may issue a repeat prescription following an assessment of need and taking into consideration continuity of care. Accountability for the prescription rests with the prescriber who has issued the prescription.

7.1.4. Prescribing should be appropriate to the patient's needs and not in response to coercion or manipulative behaviour.

7.2. **Gifts and benefits**

7.2.1. The advertising and promotion of medicines is strictly regulated, and it is important that prescribers make their choice of medicinal product for their patients on the basis of clinical suitability and value for money alone.

7.2.2. Non-medical prescribers must abide by their professional code of conduct and service area policies when dealing with representatives of the pharmaceutical industry.

7.3. **Stock items**

7.3.1. Non-medical prescribers cannot write stock prescriptions.

7.4. **Informing Patients**

7.4.1. Non-medical prescribers must ensure that patients are aware of the scope and limits of non-medical prescribing and how the patient can obtain other items necessary for their care.

7.5. **Prescribing for self and family**

7.5.1. Non-medical prescribers must not prescribe for themselves or members of their family.

7.6. **Who to write prescriptions for**

7.6.1. Practice nurse prescribers may only issue prescriptions for the patients of the practice at which they are employed.

7.6.2. Community Health prescribers may only issue prescriptions for the patients on their active caseload or in their designated clinical area of care.

7.6.3. Hospital based prescribers should only prescribe for patients in the clinic or ward they are employed to work or for patients in their area of clinical responsibility, (e.g. where hospital based prescribers provide services in the community, or vice-versa, as part of an in reach or outreach team).

7.6.4. Non-medical prescribers can prescribe for patients who are temporarily resident on the Isle of Man within the confines of the prescriber's area of competence. N.B. – other than prescription charges, temporary residents from the UK and Northern Ireland do not have to pay for immediate and necessary treatment, i.e. anything that cannot be foreseen; for any other treatment they can be charged.

7.7. Private Prescriptions

7.7.1. Private prescribing by non-medical prescribers does not form part of any health service or mental health service contract.

7.7.2. Health service prescription pads and documentation must **not** be used for private practice.

7.7.3. Non-medical prescribers who plan to privately prescribe must inform the Non-medical prescribing Lead and their employer of their intention.

7.7.4. Advice from relevant professional bodies must be sought and followed by any non-medical prescribers wishing to practice privately and issue private prescriptions.

7.7.5. Practitioners undertaking private work are not covered by DHSC insurance and will, therefore, need to arrange their own professional indemnity cover.

7.8. Prescribing and Supply of Medicines by the same Non-medical prescriber

7.8.1. The prescribing and supplying of medication must be kept as two separate activities apart from in exceptional circumstances, when it is in the patient's best interest to do so. When it is not possible to separate the duties, the prescriber should have the supply of the medication witnessed and signed by another practitioner or competent individual. If this is not possible, then a rationale should be documented in the patient's record as to why the prescriber has had to prescribe and supply.

In March 2020, the RCN clarified that the word 'exceptional' should be used to describe an area where NMPs routinely prescribe, supply and/or administer medication as lone practitioners.
Manx Care recognises that practitioners working in the Manx Emergency Doctors Service, Genitourinary Clinic, Air Ambulance and General Practice, regularly (or occasionally) prescribe, supply and administer as routine practice. As such, their rationale for this practice must be documented in the patient's records and a risk assessment undertaken in each work area – as per the RCNs advice (see Appendix H).

7.9. Incident Reporting

7.9.1. Any untoward incidents must be reported within local risk management or clinical governance schemes – see Appendix E for Non-medical prescribing incident flow chart. (This is separate from Adverse Reaction Reporting – see Point 10 of Part 1).

8. RECORD KEEPING

8.1. Good practice

8.1.1. All prescribers are required to keep contemporaneous records, which are unambiguous and legible according to their professional body's guidelines. The NMC Guidelines for Record Keeping (2010) are recommended for all prescribers as a good example of guidance.

8.1.2. Shared records for patients are the safest option.

8.1.3. Where shared records are not used, details of the prescription must be entered into the practitioner's records (and any patient held records), at the time of writing, and the patient's General or Medical Practitioner must be informed, (see Point 8.2 of Part 1).

8.1.4. The record must clearly indicate the date, the name of the prescriber and full details of the items prescribed including any advice and/or written information given to the patient.

8.1.5. For items to be ingested or inserted into the body, the strength of the preparation, the dosing schedule and route of administration must be recorded.

8.1.6. For topical medicinal preparations, the strength, the quantity to be applied and the frequency of application must be written in the records.

8.1.7. For dressings and appliances methods of use must be written in the records.

8.2. Notifying General/Medical Practitioners of Non-Medical Prescriptions

8.2.1. The patient's General or Medical Practitioner will be notified of every prescription using form NMP1 [Appendix F] or in the case of hospital in-patients on the coding form issued on discharge. The maximum time allowed between writing the prescription and notifying the General or Medical Practitioner is 24 hours, with the exception of bank holidays and weekends when notification will be on the next working day.

NB: This section will be overridden if local policies for practitioners state otherwise, e.g. sexual health services do not inform GPs routinely of patients who attend.

8.2.2. In some circumstances it may be necessary in the professional judgement of the prescriber to advise the General / Medical Practitioner immediately of the prescription. This action should be recorded in the prescriber's records immediately.

9. ADVERSE REACTION REPORTING

9.1. The Yellow Card Adverse Drug Reaction Reporting Scheme is a scheme through which Practitioners must notify suspected adverse reactions to medicines to the Medicines and Healthcare Products Regulatory Agency (MHRA).

9.2. When an adverse reaction is reported to the MHRA a copy of the yellow card (located in the back of the British National Formulary) must be filed or scanned into the patient records. Alternatively, reactions may be reported to MHRA electronically, via: https://yellowcard.mhra.gov.uk/

A copy of the report can then be printed for the patient's record.

10. LEGAL AND CLINICAL LIABILITY

10.1. Liability of Employer and Professional Liability

Where a non-medical prescriber is appropriately trained and qualified and prescribes as part of her/his professional duties as described in their job description and with the consent of her/his employer, the employer is held vicariously liable for her/his actions. In addition, non-medical prescribers are individually and professionally accountable to their professional body for this aspect of their practice, as for any other, and must act at all times in accordance with their professional body's Code of Professional Conduct and Scope of Professional Practice.

10.1.1. Private sector non-medical prescribers and practice nurses must ensure that either they or their employer holds adequate insurance relating to non-medical prescribing.

PART 2: SUPPLEMENTARY PRESCRIBING

1. WHAT CAN BE PRESCRIBED?

Supplementary prescribers prescribe in partnership with a doctor or dentist, (the independent prescriber). They are able to prescribe all medicines - with the exceptions of diamorphine, cocaine and dipipanone for the treatment of addiction. They may prescribe medication and/or appliances for a full range of medical conditions, provided that they do so under the terms of a patient specific Clinical Management Plan (CMP). The CMP will be drawn up, with the patient's agreement, following diagnosis by the independent prescriber.

2. HOW SUPPLEMENTARY PRESCRIBING WORKS

2.1. General Principles

2.1.1. The independent prescriber **must** be a doctor or dentist. It is for the independent prescriber to determine which patients may benefit from supplementary prescribing.

2.1.2. Supplementary prescribing is a voluntary partnership between the independent and the supplementary prescriber, who between them should draw up and agree an individual CMP for the patient's condition before supplementary prescribing begins. Two sample draft templates, which are attached as Appendices G[1] and G[2], should help with this. The templates have been produced to help develop CMPs more easily. The use of these templates is not mandatory. They can also be adapted/amended to suit local needs, or in some cases, it may be appropriate to develop CMPs from scratch. There **must**, however, always be an individual CMP. Detailed information on what should be included in the CMP is set out in Point 10 of Part 2.

2.1.3. In each case the independent and/or supplementary prescriber should obtain the patient's agreement to supplementary prescribing taking place and then discuss and agree the CMP for that particular patient. The independent and supplementary prescribers must maintain communication while the supplementary prescriber is reviewing and prescribing for the patient.

2.1.4. There should be a formal clinical review within 12 months of the start of the CMP. If a joint clinical review is not possible, the outcome of the clinical review by the independent prescriber needs to be discussed with the supplementary prescriber, who must agree continuation of, or changes to, the CMP.

2.1.5. The independent prescriber should be the clinician responsible for the individual's care at the time that supplementary prescribing is to start. If this responsibility moves from one independent prescriber to another (for example from the patient's GP to a hospital consultant, or from one GP to another), the supplementary prescriber cannot continue to prescribe, until the new independent prescriber's name is recorded on the CMP and the agreement of all concerned has been recorded. Supplementary prescribing partnerships involving more than one independent prescriber (e.g., shared care arrangements) are referred to in Point 6.2 of Part 2.

3. CHARACTERISTICS OF SUPPLEMENTARY PRESCRIBING

3.1. **The key characteristics of supplementary prescribing are:**

3.1.1. Supplementary prescribing may only take place after a specified point in the individual patient episode, i.e., after assessment and diagnosis by an independent prescriber and the development of a written CMP agreed between the independent and supplementary prescriber.

3.1.2. The independent prescriber is responsible for the diagnosis and, although they need not personally draw it up, the parameters of the CMP must be mutually agreed by independent and supplementary prescribers.

3.1.3. The supplementary prescriber has discretion in the choice of dosage, frequency, product and other variables in relation to medicines within the limits specified by the CMP. The Plan may include reference to recognised and authoritative clinical guidelines and guidance (local or national), whether written or electronic, as an alternative to listing medicines individually. Any guidelines referred to should be readily accessible to the supplementary prescriber when managing the patient's care (see also Point 10 of Part 2).

3.1.4. Responsibility for the patient's care can be returned to the independent prescriber at the request of anyone in the partnership.

3.1.5. The independent prescriber and the supplementary prescriber must share access to, consult, keep up to date, and use the same common patient record to ensure patient safety.

3.1.6. Nurses, optometrists, pharmacists, physiotherapists, podiatrists, radiographers and dietitians may become supplementary prescribers and, once qualified, may prescribe any medicine within their clinical competence, according to the CMP.

4. RELATIONSHIP BETWEEN THE INDEPENDENT AND SUPPLEMENTARY PRESCRIBERS

4.1. The key to safe and effective supplementary prescribing is the relationship between all prescribers. These professionals should:

4.1.1. Be able to communicate easily.

4.1.2. Share access to, consult, keep up-to-date and use the same common patient record.

4.1.3. Share access to the same local or national guidelines or protocols, where these are referred to in the CMP.

4.1.4. Agree and share a common understanding of, and access to, the written CMP.

4.1.5. Ideally, jointly review the patient's progress at agreed intervals.

5. RESPONSIBILITIES

5.1. **The independent prescriber is responsible for:**

5.1.1. The initial clinical assessment of the patient, the formulation of the diagnosis and determining the scope of the CMP.

5.1.2. Reaching an agreement with the supplementary prescriber about the limits of their responsibility for prescribing and review – which should be set out in the CMP.

5.1.3. Providing advice and support to the supplementary prescriber as requested.

5.1.4. Carrying out a review of the patient's progress at appropriate intervals, depending on the nature and stability of a patient's condition.

5.1.5. Sharing the patient's record with the supplementary prescriber.

5.2. **The supplementary prescriber is responsible for:**

5.2.1. Prescribing for the patient in accordance with the CMP. Altering the medicines prescribed, within the limits set out in the CMP, if monitoring of the patient's progress indicates that this is clinically appropriate.

5.2.2. Monitoring and assessing the patient's progress as appropriate to the patient's condition and the medicines prescribed.

5.2.3. Working at all times within their clinical competence, and their Professional Code of Conduct, and consulting the independent prescriber as necessary.

5.2.4. Accepting professional accountability and clinical responsibility for their prescribing practice.

5.2.5. Passing prescribing responsibility back to the independent prescriber if the agreed clinical reviews are not carried out within the specified interval (see paragraph 2.1.4 above); or if they feel that the patient's condition no longer falls within their competence, or if any referral criteria stated on the CMP are met.

5.2.6. Recording prescribing and monitoring activity, in the shared patient record, contemporaneously or as soon as possible. **Only in exceptional circumstances should this period exceed 24 hours.**

6. WORKING TOGETHER

6.1. Independent and supplementary prescribers must be willing and able to work together and to assume the specific responsibilities listed above.

6.2. Independent and supplementary prescribers may work in more than one prescribing partnership, providing that (in each case) they work as described above.

7. THE PROCESS

7.1. Before starting to undertake supplementary prescribing, the supplementary prescriber will need to:

7.1.1. Reach agreement with their employer that supplementary prescribing should form part of their professional responsibilities and be added to their job descriptions to reflect this.

7.1.2. Successfully complete the specified training and preparation for supplementary prescribing, including all assessments and the period of learning in practice.

7.1.3. Ensure that their supplementary prescribing competency is recorded on the relevant professional register (e.g. Nursing and Midwifery Council, Royal Pharmaceutical Society of Great Britain or Health and Care Professions Council).

7.1.4. Make arrangements with their employer and /or the independent prescriber for access to prescription pads or other mechanisms for prescribing which are appropriate to the setting, for example patients' drug charts in hospitals.

8. CONDITIONS AND HEALTH NEEDS THAT CAN BE INCLUDED

8.1. There are no legal restrictions on the clinical conditions that may be managed by a supplementary prescriber. Supplementary prescribing is primarily intended for use in specific chronic medical conditions or health needs affecting the patient. However, acute episodes occurring within chronic conditions may be included in these arrangements, provided they are included in the CMP.

9. PATIENT'S CONSENT

9.1. Wherever it is proposed to manage a patient's condition through the use of supplementary prescribing, the principle underlying the concept of supplementary prescribing (i.e. a prescribing partnership), must be explained in advance to the patient by the independent or supplementary prescriber and valid consent obtained.

9.2. The patient's consent to the prescribing partnership should be recorded in the CMP and patient record (it is not necessary for the patient to sign the CMP, but an indication of consent must be recorded). Without such consent, supplementary prescribing must **not** proceed.

Local consent policies must be adhered to.

10. THE CLINICAL MANAGEMENT PLAN

10.1. The Clinical Management Plan is the foundation of supplementary prescribing. Before supplementary prescribing can take place, it is obligatory for an agreed CMP to be in place (written or electronic) relating to a named patient and to that patient's specific condition(s) to be managed by the supplementary prescriber. This should be included in the patient record. Regulations specify that the CMP must include the following:

10.1.1. The name of the patient to whom the plan relates.

10.1.2. The illness or conditions which may be treated by the supplementary prescriber.

10.1.3. The date on which the plan is to take effect, and when it is to be reviewed by the doctor or dentist who is party to the plan.

10.1.4. Reference to the class or description of medicines or types of appliances which may be prescribed or administered under the plan.

10.1.5. Any restrictions or limitations as to the strength or dose of any medicine which may be prescribed or administered under the plan.

10.1.6. Any period of administration or use of any medicine or appliance which may be prescribed or administered under the plan.

Please note: The CMP may include a reference to published national or local guidelines. However, these must clearly identify the range of the relevant medicinal products to be used in the treatment of the patient, and the CMP should draw attention to the relevant part of the guideline. These guidelines must be easily accessible.

10.1.7. Relevant warnings about any known sensitivities or difficulties the patient may have with particular medicines or appliances.

10.1.8. The arrangements for notification of:

a) Suspected or known reactions to any medicine which may be prescribed or administered under the plan; and suspected or known adverse reactions to any other medicine taken at the same time as any medicine prescribed or administered under the plan. *See Point 9 of Part 1: Adverse Reaction Reporting.*

b) The circumstances in which the supplementary prescriber should refer to, or seek the advice of, the doctor or dentist who is party to the plan.

10.2. The CMP should be kept as simple as possible. It may refer to national or local evidence-based guidelines to identify the medicines that are to be prescribed; or circumstances in which dosage, frequency or formulation should be changed. There is, however, no need to repeat the advice provided in these guidelines in the body of the CMP itself. Nor is there a need to repeat detailed patient information that is contained in the patient's record, if it is accessible by both prescribers, unless such information is essential for clarity and patient safety.

10.3. Following diagnosis by the independent prescriber, the independent and supplementary prescriber must discuss the CMP before the document itself is prepared. Either the independent or supplementary prescriber may draft the CMP; however, both must formally agree to the CMP before supplementary prescribing can begin.

10.4. The independent prescriber and supplementary prescriber must share access to, consult and use the same common patient record. Shared electronic records are ideal, but existing paper records or patient-held records, can also be used. The CMP may need to contain different levels of detail, if the independent and supplementary prescriber work in different locations (e.g., a hospital-based independent prescriber and an outreach supplementary prescriber in the patient's home). See appendices G[1] and G[2] for example CMP templates.

10.5. In addition to planned reviews, the CMP can be terminated, at any time, for the following reasons:

- At the discretion of the independent prescriber.
- At the request of the supplementary prescriber or the patient.
- When there is a sole independent prescriber and he or she is replaced for whatever reason. In these circumstances the CMP must be reviewed by their successor and signed by them (if they agree).

11. MEDICINES TO BE PRESCRIBED BY SUPPLEMENTARY PRESCRIBERS

11.1. There is no specific formulary or list of medicines for supplementary prescribing. Provided medicines are prescribable by a doctor or dentist (an independent prescriber), at NHS expense, and are referred to in the patient's CMP; supplementary prescribers are able to prescribe:

- All General Sales List (GSL) medicines and all Pharmacy (P) medicines.
- Appliances and devices prescribable by GPs.
- Food and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All Prescription Only Medicines including controlled drugs.
- Any controlled drugs as long as it is within the Clinical Management Plan specific to that patient and agreed between the independent prescriber (doctor or dentist), supplementary prescriber and the patient.

- Medicines for use outside their licensed indications (i.e. 'off label' prescribing), 'black triangle' drugs, and drugs marked 'less suitable for prescribing' in the BNF.

  NB: Unlicensed drugs may not be prescribed unless they are part of a clinical trial that has a clinical trial certificate or exemption.

11.2. In addition, the supplementary prescriber should not prescribe any medicine that they do not feel competent to prescribe.

12. THE JOINT CLINICAL REVIEW

12.1. This review must take place at the interval stated in the CMP. This may be a joint review by both prescribers seeing the patient together. Where this is not possible, the independent prescriber should review the patient, and subsequently discuss future management of the patient's condition(s) with the supplementary prescriber. Both prescribers must record their agreement to the continuing or amended CMP, and the patient's agreement to the continuation of the supplementary prescribing arrangement, in order for the CMP to remain valid. They should then set a new date for review.

Prescribing by the supplementary prescriber after the date of review, and without recorded agreement to the next phase of the CMP, should not continue.

12.2. CAMHS in consultation with the lead non-medical prescriber and the Lead Nurse/ Clinical Governance Manager in the Mental Health Service have agreed that the review of the CMP (as detailed in section 12.1) may occur within clinical supervision between the independent prescriber (Consultant Child and Adolescent Psychiatrist) and the new supplementary prescriber (Clinical Nurse Specialist). The review by the Consultant Child and Adolescent Psychiatrist will then be fully discussed with the patient to avoid duplication of appointments with both prescribers.

13. PATIENT RECORDS

13.1. All professionals are required to keep accurate, legible, unambiguous and contemporaneous records of patients' care. There is no single model or template for a patient record, but a good record is one that provides all professionals involved in a patient's treatment, with the information necessary for them to care safely and effectively for that patient. It is an invaluable way of promoting communication within the healthcare team and between practitioners and their patients /clients. Good record keeping is therefore, both the product of effective team working, and a tool in promoting high quality healthcare. Arrangements for the sharing of patient records should be put into place at the same time as the supplementary prescribing partnership is set up.

13.2. Best practice dictates that the details of any prescription (together with other details of the consultation with the patient) should be entered on to the shared patient record immediately or as soon as possible after the consultation. **Only in exceptional circumstances should this period exceed 24 hours from the time of writing the prescription.** Should separate nursing notes be held, this information must be recorded

in them at the same time, and the patient's GP informed (if he/she is not the prescribing partner).

13.3. It is essential that the entry clearly records:

13.3.1. Details of the consultation;

13.3.2. The date of the prescription;

13.3.3. The name of the prescriber (together with the fact that they are acting as a supplementary prescriber);

13.3.4. The name of the item prescribed, together with the quantity, dose, frequency and treatment duration.

13.3.5. It is also recommended that any advice given is recorded.

13.4. In some circumstances, it may be necessary (in the professional judgement of the supplementary prescriber), to advise the independent prescriber immediately about the prescription. This action should be recorded in the shared patient record.

REFERENCES AND APPENDICES

References/Resources

Department of Health (2006). *Improving Patient's Access to Medications: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within NHS in England.* Available at: https://webarchive.nationalarchives.gov.uk/20130105033522/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4133747.pdf
[Accessed 5/2/21]

Isle of Man 'The Misuse of Drugs Act – 1976. Available online: https://legislation.gov.im/cms/images/LEGISLATION/PRINCIPAL/1976/1976-0021/MisuseofDrugsAct1976.pdf?zoom_highlight=misuse+of+drugs#search=%22misuse%20of%20drugs%22
[Accessed 5/3/21]

National Prescribing Centre (2010). *Non-medical Prescribing: A quick guide for commissioners.* Available online: https://static1.squarespace.com/static/515ab73de4b01cd3b024edd0/t/51eefaf8e4b0de4b8d276d80/1374616312229/NMP_QuickGuide.pdf

NICE/BNF (2021). *Non-medical prescribing: overview.* Available online: https://bnf.nice.org.uk/guidance/non-medical-prescribing.html
[Accessed 11/2/21]

RCN (Jan 2021). *Non-medical prescribers.* Available at: https://www.rcn.org.uk/get-help/rcn-advice/non-medical-prescribers
[Accessed 5/2/21]

RCN/RPS (2019). *Non–medical prescribing policy: The joint RN/RPS document 'Professional Guidance on the Administration of Medicines in Healthcare settings.* Available online: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567
[Accessed 5/2/21]

RPS (July 2026). *A Competency Framework for all Prescribers.* Available at: https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Prescribing%20competency%20framework/prescribing-competency-framework.pdf
[Accessed 29/3/21]

Appendices

Appendix A

MANX CARE
NON-MEDICAL PRESCRIBING PRACTITIONER CONTRACT

Practitioner:	**Profession:**
Department:	**Care Group:**

The purpose of this contract is to ensure that non-medical prescribing is undertaken in a safe and effective manner within Manx Care.

The right to practice as a Non-medical Prescriber (NMP), within Manx Care, may be revoked if the practitioner fails to adhere to the following standards:

Consultation

- The patient must be fully informed; and consent to a Non-medical prescriber being involved in their care.
- The Non-medical Prescriber will conduct a full assessment of the patient; and provide them with every opportunity to ask questions and take an active part in their treatment.
- Follow up arrangements should be agreed at each consultation; and the patient provided with contact details of the relevant medical team.

Prescribing

- Non-medical prescribers must adhere to local policy, and follow national guidelines, at all times.
- Non-medical Prescribers must only prescribe within their scope of competency and remit.
- All medication prescribed will be within the following personal formulary:

Documentation

- The issuing of prescriptions, along with consultation details, must be clearly recorded in the patient's medical record; in accordance with the IOM Non-Medical Prescribing and Record Keeping policies.

Accountability

- The Non-medical Prescriber is accountable for any medication that he or she prescribes; and must only prescribe a drug if competent to do so.
- The non-medical prescribing role will be incorporated into the practitioner's job description.
- All V300 non-medical prescribers must participate in audits/self-assessments when requested by the NMP Lead.

Supporting documentation

Noble's hospital Formulary (current edition)
British National Formulary (current edition)
IOM Non-Medical Prescribing Policy (Mar 2021)
DHSC All Island Medicines Policy (2019).

Please list any further supporting documentation specific to your area:

_____

_____

_____

Agreement

To practise within Manx Care, the Non-medical Prescriber must have authority from their line manager, and the senior doctor (within their area of work).

The following section must be completed to demonstrate that all three parties have agreed to the contents of this contract:

	Line Manager	**Lead Doctor**	**Practitioner**
Name			
Signature			
Date			

Appendix B

NOTIFICATION OF NEWLY QUALIFIED NON-MEDICAL PRESCRIBER/CHANGE IN CIRCUMSTANCES

Full name of prescriber:	Date qualified:
Profession:	Regulatory body PIN:
Role and place of employment:	

Please tick as appropriate:

- ☐ **Newly qualified Non-medical Prescriber (complete section A).**
- ☐ **NMP leaving their role or no longer prescribing (complete section B).**
- ☐ **NMP – name change (complete section C).**

SECTION A: NEWLY QUALIFIED PRESCRIBER

Prescribing qualification (please tick): ☐ V100 ☐ V150 ☐ V300	Date qualified:
Tick to confirm: ☐ My prescribing qualification has been acknowledged by my regulatory body. ☐ I have signed and submitted my Manx Care Contract.	
Signature:	Date:

SECTION B: NO LONGER PRESCRIBING*

Date prescribing to cease from:	Reason:
Signature:	Date:

SECTION C: NAME CHANGE*

Date name to change from:	New name:
Signature:	Date:

**Practitioners completing sections B or C must return all unused prescription pads to the Admin Office, 1st Floor, Crookall House/Noble's Pharmacy*

Appendix C

CRITERIA FOR ENTRY TO TRAINING

To be considered for the Independent/Supplementary Prescribing (V300) course (currently in conjunction with Keyll Darree), applicants must:

i) Have the ability to study at level 6/7.

ii) Have three years post registration clinical experience.

iii) Be working in an area that warrants the qualification (in that the practitioner has their own caseload of patients) and demonstrate the appropriate level of clinical competence.

iv) Have management support.

v) Have access to two registered prescribers: one to act as practice assessor and one as practice supervisor.

Prospective candidates will go through an interview and selection process.

Appendix D[1]

Policy Statement - Prescription Pad Security and Safe Handling

The prescription pad is the property of Manx Care.

It is the responsibility of the prescriber to ensure the security of the pad at all times.

Prescription Pad

1. The prescription pads for Non-medical Prescribers are coloured differently for easy identification by pharmacists and the Prescription Pricing Authority. Pharmacists use lilac-coloured prescription pads, but all other NMPs use green HS10 pads with the type of prescriber printed on them.

2. The prescriber should complete all details on the prescription form by writing clearly and legibly using an indelible black pen, the patient's surname and first name, date of birth and full address. The name (plus size and strength, if any) of the prescribed item, dosage and frequency, signing and dating are all essential for the proper completion of the HS10 (CN/PN).

Security

1. The security of forms is the responsibility of the prescriber.

2. In the event of loss or suspected theft, community based practitioners must report this immediately to the Pharmaceutical Advisor and their line manager. Practice Nurses must report this to the GP and Pharmaceutical Advisor. Noble's Hospital prescribers must report this to the Pharmacy Department at Noble's Hospital Department and Line Manager.

3. Under no circumstances should blank prescription forms be pre-signed before use. The prescription form should only be produced when needed, and never left unattended.

4. Prescription pads must be placed in a lockable drawer. They should not be left on display.

5. For community practitioners, when travelling between patients the prescription pad should not be visible.

6. The prescription pad **must always** be removed from the car when the car is unattended.

7. Non-medical prescribers cannot issue prescriptions on behalf of other practitioners who are not qualified non-medical prescribers.

8. **Prescription pads must be returned to the Community Nursing Department/the Pharmacy Department at Noble's Hospital Department on or before last day of employment.**

Appendix D[2]

Stolen HS10 Forms - Procedure

Responsibility

In the event of lost or stolen prescription forms the following steps must ensue:

1. The prescriber will inform:

   - The Pharmaceutical Advisor (for community based prescribers)
   - The Pharmacy Department at Noble's Hospital (for hospital based prescribers)
   - GP (for Practice Nurses)
   - Line Manager (all prescribers)

   Giving approximate numbers of scripts stolen/lost and details, if known, of where and when they were stolen/lost.

2. The Pharmaceutical Advisor will inform local pharmacies of the above information as soon as possible.

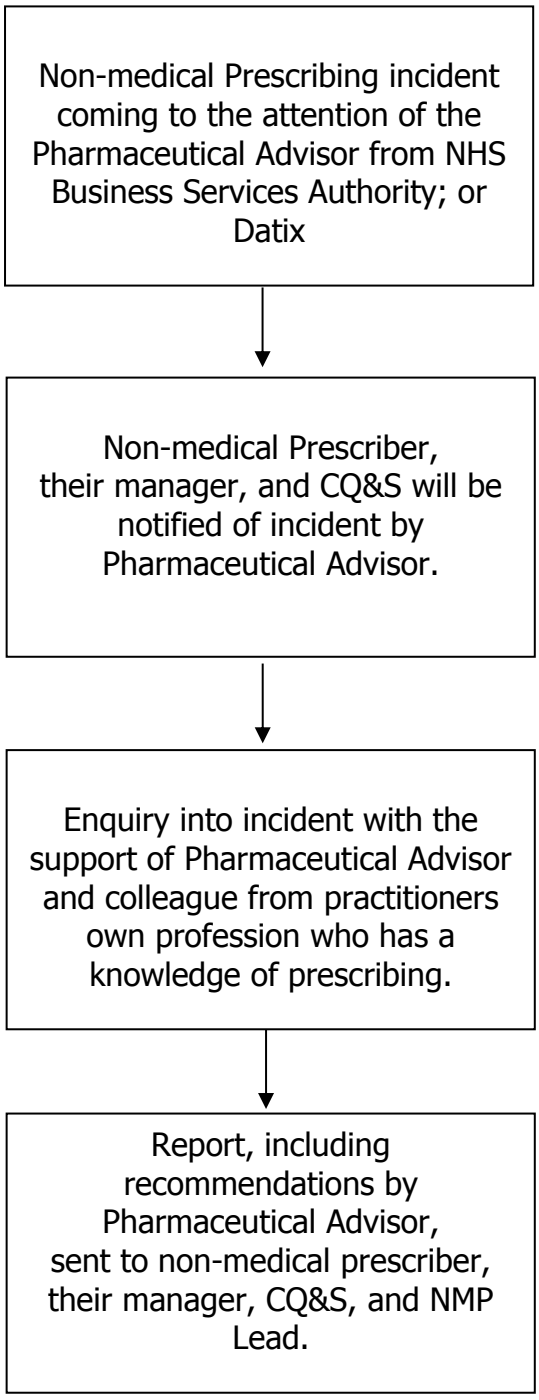
3. The Pharmaceutical Advisor will inform the prescriber to write and sign all scripts in a particular colour (usually red) for a period of 2 months.
   Computer scripts should be signed and dated in the same colour.

4. The Pharmaceutical Advisor will inform all pharmacies in the area of the name and address of the prescriber concerned, and the period within which the prescriber will write in a specific colour. This will be confirmed in writing within 24 hours with the exception of weekends.

Appendix E

Non-medical Prescribing Incident Flow Chart

Incidents coming to the notice of others should be reported (as per local incident reporting policy) and the Pharmaceutical Advisor added as an investigator on Datix.



Appendix F

MANX CARE

Notification to GP of Non-medical Prescription

Patients Name ..... Date of Birth .....

Address .....

.....

..... GP .....

Assessment **Items Prescribed** **Follow Up Plan**

Please enter on to Patient's GP Records

Name of Prescriber **Designation** **Base** **Contact Number**

Signature ..... Date .....

MANX CARE

Notification to GP of Non-medical Prescription

Patients Name ..... Date of Birth .....

Address .....

.....

..... GP .....

Assessment **Items Prescribed** **Follow Up Plan**

Please enter on to Patient's GP Records

Name of Prescriber **Designation** **Base** **Contact Number**

Signature ..... Date .....

Appendix G[1]

TEMPLATE CMP 1 (Blank): for teams that have full joint access to patient records

Name of Patient:		**Patient medication sensitivities/allergies:**	
Patient identification (e.g., ID number, date of birth):			
Independent Prescribers(s):		**Supplementary Prescriber(s):**	
Condition(s) to be treated:		**Aim of treatment:**	
Medicines that may be prescribed by SP:			
Preparation:	**Indication:**	**Dose schedule:**	**Specific indications for referral back to the IP:**
Guidelines or protocols supporting Clinical Management Plan:			
Frequency of review and monitoring by:			
Supplementary prescriber:	**Supplementary prescriber and independent prescriber**		
Process for reporting ADRs:			
Shared record to be used by IP and SP:			

Agreed by independent prescriber(s)	**Date**	**Agreed by supplementary prescriber(s)**	**Date**	**Date agreed with patient/carer:**

Appendix G[2]

TEMPLATE CMP 2 (Blank): for teams where the Supplementary Prescriber has separate patient records

Name of Patient:		**Patient medication sensitivities/allergies:**	
Patient identification e.g. ID number, date of birth:			
Current medication:		**Medical history:**	
Independent prescriber(s): **Contact Details: [tel/email/address]**		**Supplementary prescriber(s)** **Contact Details: [tel/email/address]**	
Condition(s) to be treated:		**Aim of treatment:**	
Medicines that may be prescribed by SP:			
Preparation:	**Indication:**	**Dose schedule:**	**Specific indications for referral back to the IP:**
Guidelines or protocols supporting Clinical Management Plan:			
Frequency of review and monitoring by:			
Supplementary prescriber:	**Supplementary prescriber and independent prescriber**		
Process for reporting ADRs:			
Shared record to be used by IP and SP:			

Agreed by independent prescriber(s)	**Date**	**Agreed by supplementary prescriber(s)**	**Date**	**Date agreed with patient/carer:**

Appendix H

RISK ASSESSMENT FOR SPECIFIC NON-MEDICAL PRACTITIONERS TO PRESCRIBE, SUPPLY AND/OR ADMINISTER MEDICATION

SERVICE AREA: ☐ Manx Emergency Doctors Service ☐ Genito-urinary Medicine ☐ Air Ambulance ☐ General Practice ☐ Other_____

Are you a lone practitioner?	Y N	
Are you an out of hours service?	Y N	
State rationale for the same person prescribing, supplying and/or administering.		
Are all stocked medications essential?	Y N	
Are packs appropriately labelled?	Y N	
Expiry dates/batch numbers recorded in patient notes?	Y N	
Are regular audits undertaken? If yes, how often? If no, why not?	Y N	

Details of person completing risk assessment:	**Name:**	**Signature:**
	Designation:	**Date assessment completed:**
Line manager: :	**Name:**	**Signature:**