South East Coast Ambulance Service NHS
NHS Foundation Trust

PRESCRIBING POLICY

Contents

1 Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to providing high quality patient care.

1.2. This policy is applicable to all Prescribers working in or on behalf of the Trust, including locum and agency staff who, in accordance with their job descriptions or terms of working, undertake prescribing as part of their role. This policy sets out the scope of clinical practice to which these health care professionals must adhere.

1 Background

1.1. The prescribing of medicines is a common intervention made as part of the treatment provided to patients. Medicines are prescribed to promote health, healing and/or wellbeing. They can, however, be harmful if prescribed, dispensed or administered incorrectly or if a patient suffers an adverse reaction.

Medicines must be prescribed in a manner that is clearly understood. This policy describes the practice that should be used when prescribing medicines and makes clear the legal and professional standards that are expected. It also aims to support and improve the safe and consistent prescribing of medicines across the interface with other care providers.

2 Purpose

2.1. This document gives clarity on organisational authority and outlines the parameters to ensure that all prescribing is managed, undertaken and governed robustly to ensure:

- Patients benefit from convenient access to treatments
- Prescribing is safe and effective
- Standards, systems and processes are in place to manage risk
- Legal, professional and statutory obligations are met

3 Scope

3.1. This document applies to all prescribing activity by prescribers working within or on behalf of The Trust and for whom prescribing is part of their specific job description and role. It does not cover staff employed by other private or NHS ambulance services/organisations working on behalf of the Trust unless specified under mutually agreed contracts/arrangements.

3.2. Staff working on rotation should not assume they can transfer their prescriber status and practice into the Trust and all Trust process and procedures need to be in place before prescribing can commence.

3.3. Staff with dual professional registration, such as being both a registered nurse and a registered paramedic, may only prescribe if annotated by the professional regulator for the role for which they are employed by the Trust.

3.4. This policy should not be read in isolation. See the Governance Framework for NMPs SOP, Trust Medicines Policy, Controlled Drugs Policy and associated SOPs, Scope of Practice and Clinical Standards Policy.

4 Who may prescribe and prescribing competency

4.1. Under United Kingdom (UK) law, only an "appropriate practitioner" can prescribe medicines in the UK. An appropriate practitioner is an:

- Independent prescriber, i.e., able to prescribe a medicine under his or her own initiative.

  This includes:

  - Doctors licensed to practice by the General Medical Council (GMC).
  - Dentists licensed to practice by the General Dental Council.
  - Healthcare professionals who have successfully completed the appropriate nationally recognised prescribing course and are registered with their professional body as a person qualified to independently prescribe (non-medical prescribers – NMPs).

4.2. NMPs must register with the Trust by following the process in the Trust Governance Framework for NMPs SOP and operational policies relating to the Trust's Electronic Prescribing System (EPS). Upon successful registration and EPS training, the NMP may prescribe according to their designation of independent prescriber status and their employment responsibility. Registered medical and dental practitioners and Non-Medical independent prescribers can prescribe from the British National Formulary (BNF) and BNF for Children (BNFC) within their core skills, scope of practice and current legislation.

4.3. Prescribers must recognise and work within the limits of their care skills and scope of practice. Prescribers should abide by the competencies identified in the Prescribing Competency Framework published by The Royal Pharmaceutical Society (RPS) and accredited by NICE, which includes a common set of competencies that form the basis for prescribing, regardless of professional background. It contains consultation and prescribing governance competencies to help healthcare professionals prepare to prescribe and provides the basis for on-going continuing education and development programmes, and revalidation processes. For example, it can be used as a framework for a portfolio to demonstrate competency in prescribing.

4.4. A prescriber should seek appropriate advice if they unsure about any aspect of prescribing or medicines management.

4.5. Prescribers, both medical and non-medical, practice in line with generic and profession specific practice guidance. This guidance is published by individual professional bodies and, while broadly consistent, does reflect the nuances in professional scope. This must be reflected in the scope of practice at trust level and in aspects such as capabilities required in service delivery (for example, repeat prescribing by clinicians with limited prescribing scopes detailed in their "Intent to Prescribe" submissions – see NMP Prescribing Governance Framework Policy and related SOPs).

5 Prescribing

5.1. **Prescription requirements:**

5.1.1. In the main prescriptions will be computer generated and sent to the pharmacy of the patient's choice, where available, by the Electronic Prescription Service (EPS). (See EPS SOP)

1.2.1. In the unlikely event of EPS failure, staff must adhere to EPS Contingency Standard Operating Procedure. A visible audit trail of prescribing actions must be maintained.

1.2.2. The accountability and legal responsibility of issuing any prescription lies with the prescriber whose name is on the prescription and is deemed to have signed that prescription both electronically or in paper format.

1.2.3. All prescribers should ensure that all the requirements for a legal prescription, are fulfilled. Details on prescription writing (including computer generated prescription requirements) is available in the BNF

1.2.4. EPS is only available when accessed via a smartcard. All prescribers must use their own smartcard to access the EPS. Smartcards must never be shared or given to other users to use.

1.2.5. Prescribers should only prescribe for a patient whom they have assessed for care and should only issue a prescription bearing their details and own unique prescriber number (professional registration PIN).

1.3. **All prescribers must:**

1.3.1. Comply with the Medicines Policy, professional guidance, appropriate legislation and other regulations relevant to their role when prescribing.

1.3.2. Keep their knowledge and skills up to date, relevant to the role and prescribing practice.

1.3.3. Recognise and work within the limits of their core skills and scope of practice.

1.3.4. Be responsible for the prescriptions that they sign.

1.3.5. Be responsible for the decisions and actions when they supply and / or administer medicines and devices and / or authorise or instruct others to do so.

1.3.6. Be prepared to explain and justify the decisions and actions when prescribing or managing medicines.

1.3.7. Ensure they have adequate professional indemnity insurance that covers them for the scope of their prescribing practice.

1.4. **In providing clinical care, prescribers must:**

1.4.1. Only prescribe within their scope of practice and core skills.

1.4.2. Only prescribe medicines when they are necessary and, in all cases, the benefit of the medicine should be considered in relation to the risks involved.

1.4.3. Prescribe only when they have adequate knowledge of the patient's health and are satisfied that the medicine serves the patient's needs.

1.4.4. Prescribe effective medicines based on the best available evidence.

1.4.5. Ensure prescriptions are clear, in accordance with the relevant statutory requirements.

1.4.6. Check that the medicine prescribed is compatible with any other medicines the patient is receiving, including 'over-the-counter' purchases and illegal substances.

1.4.7. Use the resources available to ensure safe and effective prescribing.

1.4.8. Discuss treatment options with the patient, ensuring a shared approach to decision-making about the medicines ('concordance') and that the patient is willing to take any medicine as prescribed. This should take into consideration any cultural, social, personal or language needs and any religious beliefs of the patient.

1.4.9. Formally record prescribing decisions in a clear, accurate and legible way. The record should be made at the same time as the event or as soon as possible afterwards.

1.5. **Repeat Prescribing**

1.5.1. Prescribers may issue repeat prescriptions but only if all of the medicines involved are within their scope of competency and practice and are included in their "Intent to Prescribe (ItP) declarations (where applicable for non-medical prescribers) as by issuing the prescription they are assuming full clinical and legal responsibility and remain accountable for their practice.

1.5.2. Prescribers should minimise risk to patients by using or developing processes that support safe prescribing particularly in areas of high risk e.g., prescribing of repeat medicines.

1.5.3. Before signing a repeat prescription, the prescriber must be satisfied that:

- It is safe and appropriate to do so.
- Each prescription is only re-issued to meet clinical need.
- There is a suitable referral pathway for patients requiring further assessment or treatment.

1.6. **Medicines Information and Resources**

1.6.1. The IUC service subscribes and has access to Medicines Complete. Routine access to the eBNF and eBNFC is available to all staff working in the service and may be accessed through https://www.nice.org.uk/About/What-we-do/Evidence-Services/British-National-Formulary

1.6.2. Complex drug information enquiries should be referred to an IUC pharmacist or a UKMI Regional Services.

1.7. **Unlicensed and off-label medicines:**

1.7.1. See the BNF to identify which prescribers can legally prescribe unlicensed and off-label medicines.

1.7.2. Prescribers should only prescribe medicines that are unlicensed (with no UK product license), off-label (used outside of UK product license) or outside standard practice if satisfied that an alternative licensed medicine would not meet the patient's clinical needs. Prescribers should refer to their profession's practice guidance with regards to these elements of prescribing.

1.7.3. Prescribers should know and work within their legal and regulatory frameworks affecting prescribing practice e.g., prescribing unlicensed and off-label medicines and the prescribing of controlled drugs.

1.7.4. Prescribers must only prescribe within organisational authority and accept professional, clinical and legal responsibility for prescribing unlicensed and off-label medicines and should only prescribe this where it is accepted clinical practice.

1.7.5. Prescribers must ensure that the patient/patient representative knows that they are being prescribed an unlicensed or off-label medication, understands the implications of this and gives their consent to this treatment.

1.8. **Hospital Only Medication**

1.8.1. Some specialist medication is only prescribed and dispensed by hospitals. These medicines must not be prescribed by the NHS 111 IUC CAS.

1.8.2. If a hospital only medication is required prescribers should liaise with the hospital pharmacy where the patient receives their usual supply or refer to the IUC CAS Pharmacist to clarify implications of missed/delayed doses

1.9. **Excessive prescribing and unwarranted variation**

1.9.1. Prescribing issues may be identified via a number of sources e.g., prescribing monitoring, incident reporting, complaints etc. Monitoring will be undertaken with the Medicines Governance team, led by the Chief Pharmacist and supported by the NMP Lead for the Trust where relevant.

1.9.2. The inappropriate or excessive use of medicines can cause distress, ill-health, hospitalisation and even death. The BMA Focus on excessive prescribing sets out what might be considered to be excessive or unwarranted prescribing for GPs but the same principles apply to all prescribers.

1.9.3. There may be occasions where prescribing may appear at significant variation with peers. Prescribing variation is open to interpretation and subsequent challenge. Where low numbers of prescribers are employed by the trust, or small numbers of a specialist clinicians are employed, the trust may seek to baseline prescribing practice against other similar organisations.

1.10. **Prescribing for self, family, friends and work colleagues:**

1.10.1. Prescribers are prohibited from prescribe for themselves.

1.10.2. Prescribers must not prescribe, dispense or access the medical records for anyone with whom they have a close personal or emotional relationship, this may include colleagues with whom they regularly work, other than in exceptional circumstances.

1.10.3. The Prescriber is responsible for determining the relationship they have with their patient and that it is appropriate to prescribe according to that assessment.

1.10.4. Prescribers should refer to the relevant professional body practice guidance and professional regulatory standards and codes of ethics for further advice.

1.11. **Private prescriptions**

1.11.1. Private prescriptions must not be issued by any Trust prescriber.

1.12. **Controlled Drugs (CDs):**

1.12.1. Prescribers should know and work within their legal and regulatory frameworks affecting prescribing practice e.g. CDs They should refer also to the Trust's CD policy, The NICE guideline on safe use and management of CDs and their respective professional body's guidance.

1.12.2. Where the prescribing of CDs is likely to cause/support dependence or misuse, the Prescriber has a responsibility to avoid creating dependence, contribute to monitoring and avoid being an unwitting source of supply for substance misusers.

1.12.3. Prescribers must ensure that all legal requirements for a CD prescription are met. These requirements are available in the BNF.

1.12.4. Schedule 2 and 3 drugs must not be prescribed by SECAmb NHS 111 IUC CAS unless the following criteria are met

- The request must be from another healthcare professional e.g., district nurse, palliative care nurse, paramedic

AND

- The patient must be under the care of a palliative care service who require a repeat prescription for a medicine(s) within their current care plan

OR

- The patient must be under the care of a palliative care service who have been assessed by an appropriate healthcare professional e.g. specialist palliative care nurse or paramedic and require an acute prescription for a new or worsening symptom(s)

OR

- The patient is not under the care of a palliative care service but has been assessed by an appropriate healthcare professional e.g. palliative care nurse or paramedic and is confirmed to be approaching the end of life and require an acute prescription for new or worsening symptom(s) or anticipatory medicine(s)

1.12.5. During normal working hours, the patient or their representative should be referred to the patient's GP. Out of hours, if the patient and call does not meet the criteria above, they should be referred to a local 24/7 primary care service providing face to face appointments.

1.12.6. If a schedule 2 or 3 drug is required and the criteria above is met, a prescription may be issued. It must meet the prescription writing requirements for Controlled Drugs.

1.12.7. Schedule 4 and 5 drugs should generally not be prescribed by SECAmb NHS 111 IUC CAS due to the high potential for misuse. Care must be taken to ensure that the patient is not repeatedly utilising the 111 IUC

CAS service to obtain scheduled substances. A 'CD Prescribing in 111' guideline is currently in development to provide clinician support.

1.12.8. If a schedule 4 or 5 drug is prescribed in exceptional circumstances the quantity prescribed should be the shortest course possible and must not exceed 7 days.

1.12.9. Any concerns identified / raised about CD prescribing or any incidents relating to CDs, should be reported to the Trust's CD Accountable Officer and Chief Pharmacist.

1.13. **Prescribing for Children**

1.13.1. Prescribers must have relevant education, training and competence in treating children in order to prescribe for them.

1.13.2. Prescribers should make reference to relevant sources of information that address medicines management issues in paediatrics including:

- BNF for children
- Royal Collage of Paediatric and Child Health – information of use of licensed and unlicensed medicines

1.13.3. Prescribers should contact the safeguarding team in the first instance for any safeguarding and/or child protection concerns.

1.14. **Prescribing in pregnancy**

1.14.1. Prescribers must establish the pregnancy status of all women of reproductive age (11 years to 60) before they issue a prescription. Where pregnancy status is unknown, the risk of prescribing must be considered.

1.14.2. If prescribing for a pregnant woman, wherever possible their GP should be informed, and the patient encouraged to inform their midwife.

1.15. **Adverse drug reactions and incidents**

1.15.1. Prescribers should detect and report suspected adverse drug reactions (ADRs) using appropriate reporting systems. The patient's GP should be notified, and the adverse reaction and subsequent actions should be documented in all the patient's medical records.

1.15.2. In addition to reporting adverse events via DATIX, all Prescribers can report any ADRs directly to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme using the electronic form at www.mhra.gov.uk/yellowcard. Alternatively, prepaid Yellow Cards for reporting are available bound in the inside back cover of the BNF. Further information on ADR reporting can be found here: https://bnf.nice.org.uk/guidance/adverse-reactions-to-drugs.html

1.15.3. Prescribers should report prescribing errors, near misses and critical incidents and review practice to prevent recurrence.

1.15.4. All patient safety incidents (prescribing errors, near misses and critical incidents) where a patient was harmed or could have been harmed, should be reported in line with local policy. These incidents should also be reported on to the National Reporting and Learning System (NRLS) – the national patient safety incident database.

1.15.5. Prescribers and other healthcare professionals should advise patients if treatment is likely to affect their ability to perform skilled tasks (e.g. driving). This applies especially to medicines with sedative effects; patients should be warned that these effects are increased by alcohol.

1.16. **Prescribing Safety Notices / Alerts**

1.16.1. The Central Alerting System is a web based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance

1.16.2. Alerts available on the Central Alert System website include safety alerts, drug alerts and medical device alerts

1.16.3. Managers and Clinical Leads must ensure the information reaches individual practitioners/users as appropriate in line with Trust policies and Cascade of Alerts**.**

1.17. **Prescribing and dispensing for Pharmacist NMPs**

1.17.1. Pharmacist NMPs should, wherever possible, separate their prescribing and dispensing roles, in keeping with the RPS Professional Guidance on the Administration of Medicines in Healthcare Settings, and principles of safety, clinical and corporate governance. In the unlikely event that this should this occur, a second suitably competent practitioner should be involved in checking the accuracy of the medication provided.

1.18. **Managing conflicts of interest**

1.18.1. Prescribers should be able to recognise and deal with factors that might unduly influence prescribing (e.g. pharmaceutical industry, media, patients and colleagues).

1.18.2. Prescribers should work within the NHS, organisational, regulatory and other codes of conduct when interacting with the pharmaceutical industry.

1.18.3. Prescribers should refer to the Association of the British Pharmaceutical Industry (ABPI) Code of Practice as well as the NHS Standards of Business Conduct policy, and their own professional regulatory standards detailing best practice in relation to gifts and other inducements.

1.19. **Allergies and hypersensitivities to medicines or excipients**

1.19.1. It is the responsibility of the prescriber to review and record allergy information before issuing a prescription.

1.19.2. Some excipient information may be available in the BNF, BNFC and in the product literature available in the electronic Medicines Compendium. Contact the manufacturer if it is essential to check the details of excipients.

6 Responsibilities

1.20. The **Chief Executive Officer** is accountable for Medicines use and governance in the Trust

1.21. **The Executive Medical Director** has responsibility for the implementation, review, and thus revision where required, of this procedure. Such review and revision(s) will be carried out on behalf of the Medical Director by the **Medicines Governance Group** (see below).

1.22. The **Executive Director of Nursing and Quality** has responsibility for matters relating to regulatory compliance, risk management, health and safety relating to this procedure.

1.23. The **Executive Director of Operations** is responsible for the operational compliance of this procedure.

1.24. **Medicines Governance Group** will interpret law, regulations, introduce new drugs, and develop procedure to guide the governance of all medicines within the Trust. The group does not deal with supply of prescription forms or operationalisation of policy.

1.25. The **Associate Director for Integrated Care (999 & 111)** is responsible for ensuring the full implementation of this procedure across the 111 IUC CAS. **The Associate Director for Integrated Care (999 & 111)** is also responsible for the full implementation, monitoring, auditing, and review of this policy.

1.26. **Chief Pharmacist** is the professional medicines governance lead for the Trust and is responsible for producing robust systems and processes which comply fully with legislation, national guidance, and regulatory requirements to ensure the safe and effective management and use of medicines throughout the Trust.

1.27. **Controlled Drug Accountable Officer** is responsible for the safe management and use of Controlled Drugs within the Trust along with co-operating and sharing information relating to concerns about the Trust's use and management under the Controlled Drug (Supervision of Management and Use) Regulations 2013.

1.28. The **Chief Executive Officer** has ultimate responsibility for the organisation and is supported by the Executive Directors.

1.29. The Incident Reporting Group is responsible for the ongoing effectiveness of this policy. The Medicines Governance Team will audit prescribing standards and report to the Medicines Governance Group.

1.30. **Prescribers** are responsible for adhering to this policy.

1.31. **All staff** should be aware that failure to adhere to this policy may result in disciplinary action, or in cases where a criminal offence may have been committed, referral to the Police or the Counter Fraud and Security Management Service. Failure to adhere to policy guidance may also result in referral to the relevant professional regulatory body where appropriate.

7 Documentation and Record Keeping

7.1. To prescribe safely, it is important to be able to access a patient's medical records. However, access may not be possible or may be limited, and there are potential risks in prescribing without these records[6]. The prescriber should assess whether they have sufficient information and knowledge of the patient's health and medical history to make an assessment of the condition. This includes using the medical records such as the summary care record (SCR) when available and with the patient's consent. prescribers should use other sources of information where possible to get a clear understanding of the patient's condition, so they are able to reduce any risks in deciding whether they can prescribe safely.

7.2. The prescriber should be able to demonstrate that they have assessed the risks when making a professional judgement, by keeping a record of their reasons to prescribe in these circumstances. A clinical record about prescribing should include:

- Relevant clinical findings.
- Decisions made and actions agreed, including who is making the decisions and undertaking the actions.
- The information provided to patients, including advice and warning, e.g. information provided on the Valproate Pregnancy Prevention Programme.
- The details of any medicines prescribed, other investigations or treatments.
- Who is documenting the record and when.

7.3. The prescriber must give clear information, so that the patient receiving care can make an informed decision and must discuss other available options when it is not appropriate to prescribe.

7.4. For every prescribing consultation, the prescriber should use their professional judgement and take into account the patient's best interests, make a risk-based assessment about whether they can prescribe safely

and make a clear record of all decisions setting out their justification for prescribing, including when they decide not to issue a prescription and the reasons why, onto the Trust electronic clinical system.

7.5. Prescribing information should be shared with the patient's prescriber or others involved in their care, so the person receives safe and effective care. The prescriber should use their professional judgement when deciding what information to share. This is especially important when prescribing medicines that are liable to abuse, overuse or misuse, when there is a risk of addiction or when ongoing monitoring is important.

7.6. Quality assurance, governance and monitoring will be undertaken on an ongoing basis using recognised and approved methods including call audits, peer review, clinical supervision and patient satisfaction surveys

7.7. In the light of the very real patient safety risks, prescribers must exercise caution when making prescribing decisions for high-risk medicines based mainly on remote assessment of the patient when there is no access to the patient's medical history or consent to contact the patient's regular prescriber. High-risk medicines are, for example, those liable to abuse, overuse or misuse, or when there is a risk of addiction or when ongoing monitoring is important.

7.8. Prescribers should not prescribe chemotherapy, oxygen therapy, complementary / alternative therapies, High-Cost Drugs excluded from the national tariff (PbR excluded drugs), "Blacklisted" items (in Part XVIIIA of the Drug Tariff) or clinical trials drugs. Any requests for these should be referred to the Medicines Governance Team.

8 Audit and Review (evaluating effectiveness)

1.32. Effectiveness of this policy will be audited by the Medicines Governance Group at regular intervals, and initially six months after a new policy is approved and disseminated.

1.33. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

1.34. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

1.35. All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

9 References

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10 Financial Checkpoint

10.1. To ensure that any financial implications of changes in policy or procedure are considered in advance of document approval, document authors are required to seek approval from the Finance Team before submitting their document for final approval.

10.2. This document has been confirmed by Finance to have no unbudgeted financial implications.

11 Equality Analysis

11.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

11.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.