Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority

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An Bord Altranais

Contents

The *Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority* replace the *Practice Standards for Nurses and Midwives with Prescriptive Authority*, 1st Edition (2007).
They come into effect on 1st December 2010.

Introduction

Prescriptive authority for nurses and midwives is founded on a dual framework of medicines legislation and professional regulation. Medicines regulations are the first framework, providing specific legal authority for a nurse or midwife to prescribe. An Bord Altranais, the statutory regulatory body for nurses and midwives, has established the second framework, the professional regulation and guidance for the registered nurse prescriber (as per its function under the *Nurses Act, 1985*).

Medicines legislation for nurse/midwife prescribing

The primary legislation - the *Irish Medicines Board (Miscellaneous Provisions) Act, 2006* - provides for amendments to medicines regulations[1] by Ministerial order for nurses and midwives to prescribe medications. The *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations, 2007 (Statutory Instrument, (S.I.) No. 201 of 2007) and the Misuse of Drugs (Amendment) Regulations, 2007 (S.I. No. 200 of 2007)* signed into law on May 1 2007 specify the legislative requirements/conditions for prescribing of medicinal products by nurses and midwives. A number of conditions must be satisfied for this authority.

They are summarised as follows:

1. The nurse/midwife must be employed by a health service provider in a hospital, nursing home, clinic or other health service setting (including any case where the health service is provided in a private home);
2. The medicinal product is one that would be given in the usual course of service provided in the health service setting in which the nurse/midwife is employed; and
3. The prescription is issued in the usual course of the provision of that health service
4. An Bord Altranais registration number (also known as the Personal Identification Number (PIN)) must be stated on the prescription.

Reference must be made to the individual regulations for full details[1].

In addition, the 2007 regulations allow a health service provider to determine further conditions for the prescriptive authority of the nurse or midwife. The prescribing of MDA-controlled drugs, is as detailed in the *Misuse of Drugs (Amendment) Regulations, 2007* which stipulates conditions for establishing a new Schedule 8 and restrictions for prescribing Schedule 4 and 5 MDAs. (This is outlined in Practice standard 4).

Professional regulation and guidance for nurse/midwife prescribing

An Bord Altranais provides for the registration, control and education of nurses/midwives and for other matters relating to nurses/midwives and the practice of nursing/midwifery and sees its overall responsibility to be in the interest and protection of the public. Prescribing is an expansion of a nurse's/midwife's scope of practice, beyond the skills, competence and knowledge an individual practitioner possesses at the point of registration.

The professional regulatory framework for nurse/midwife prescribing is established through the *Nurses Rules, 2007*, amended by the *Nurses Rules 2010*, which allows for the creation of a division of the Register for Nurse Prescribers[2]. The *Requirements and Standards for the Education Programme for Nurses and Midwives with Prescriptive Authority,* (An Bord Altranais, 2007) defines the competencies

[1] The specific regulations which have been amended are the *Medicinal Products (Prescription and Control of Supply) Regulations 2003 (S.I. No. 540 of 2003)* and the *Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988)* as amended by the Misuse of Drugs (Amendment) Regulations 1993 (S.I. No. 342 of 1993).

[2] Currently, within the *Nurses Act, 1985* a midwife is registered within a division of the Nurses Register, therefore a midwife with prescriptive authority is registered as a Nurse Prescriber.

that must be attained through successful completion of the programme. Building upon these foundations are the remaining elements of the Board's framework, which are:

- *Decision-Making Framework for Nurse/Midwife Prescribing*, (2007)

  This is a graphic representation of the structures and processes that should be in place for the nurse or midwife to prescribe. The diagram illustrates a rational step-by-step approach in which to consider the context and appropriateness of prescribing and the necessary clinical governance supports.

- *Collaborative Practice Agreement* (CPA), (2007) is referred to in the above framework.

- An Bord Altranais guidance documents

  - *Guidance to Nurses and Midwives on Medication Management* (2007)
  - *Recording Clinical Practice - Guidance to Nurses and Midwives* (2002)
  - *Practice Standards for Midwives* (2010)
  - *The Code of Professional Conduct for each Nurse and Midwife* (2000)
  - *Scope of Nursing and Midwifery Practice Framework* (2000)

- *Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority* (2010)

Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority

The professional responsibilities of the nurse and midwife are addressed in the *Practice Standards and Guidelines* that follow and should be viewed as the overarching mechanism with which a nurse/midwife is expected to practice. These specific standards, along with the Decision-Making Framework, CPA and guidance documents, outline the requirements of An Bord Altranais for the registered nurse prescriber. The *Practice Standards and Guidelines* augment the clinical governance structures required at local and national levels to support safe and professional practices for the implementation of nurse and midwife prescribing.

Prescribing practice involves a number of complex skills including comprehensive consultation, diagnosis, information giving and accurate documentation. Consultation with a patient/service-user during the prescribing process and the correct completion of a prescription enhances patient/service-user safety and reduces the likelihood of a medication error (World Health Organisation, 1994; Latter S., Maben J., Myall M. and Young A. 2007).

The rationale for providing these standards and guidelines is as follows (National Prescribing Centre, 2007):

1. Nurses and midwives with prescriptive authority are prescribing a wide range of medications across diverse patient/service-user populations that have the potential to interact; therefore there is the increased possibility of medication errors and drug interactions.
2. Prescribing is shared among different groups of health professionals therefore it is important that prescribing processes and outcomes are comprehensively documented and communicated.
3. Safe and effective prescribing practice will lead to improved patient/service-user outcomes and reduce the incidence of adverse events related to medication.

Two key elements in good prescribing practice are minimising risk and maximising effectiveness (Barber, 1995). In minimising risk it is important to note that prescribing is a complex process and may be associated with adverse events and unintended consequences. Therefore, it is important that the Registered Nurse Prescriber (RNP)[3] has a good understanding of the medication that is being prescribed including possible side-effects and the interaction the medication may have with other medications. It is also important that risk is minimised through comprehensive and accurate recording of the prescribing consultation. Although it is recognised that risk cannot be fully eliminated the RNP should take all steps to ensure that risk is minimised. In maximising effectiveness it is good practice to monitor the impact of the medication prescribed. For example if analgesia is prescribed for pain it is important to record its effectiveness through pain scores or other forms of measurement.

It is also essential in the prescribing consultation to respect the patient's/service-user's choice. There are two principles in this regard: first the RNP should listen to the patient's/service-user's concerns and needs and, secondly, the RNP should ensure that the patient/service-user is educated and informed so that he/she understands his/her medication regimen (Barber, 1995).

Objectives:

The objectives for the Practice Standards are to:

- Provide professional guidance for prescriptive authority and associated areas of medication management

[3] The term Registered Nurse Prescriber (RNP) is used throughout the document to indicate nurses and midwives with prescriptive authority.

- Enable RNPs to demonstrate the key competencies and practice elements associated with this authority and related principles to ensure safe, competent, effective and ethical practice
- Ensure appropriate mechanisms of clinical and self-governance are in place relating to the prescriber's scope of practice
- Outline a regulatory framework for nurses and midwives for the continuum of their prescribing authority/practices
- Assure the public of the competence and professional accountability of the RNP
- Support the twin track approach to the regulation of RNPs.

Each practice standard is described and is accompanied by supporting rationale(s), guidance for practice and reference to the specific competencies for the RNP.

The standards and guidelines outlined in this document are intended as a guide towards best practice, but should always be used in conjunction with professional judgement.

Practice Standards

Practice Standard 1. Clinical Decision-Making Process

Nurse and midwife prescribing is underpinned by a number of principles. These include the RNP's scope of practice, their Collaborative Practice Agreement (CPA) (An Bord ALtranais, 2007), their core competencies and their decision-making processes. A systematic clinical decision-making process should inform the decision to prescribe.

Rationale

Nurse and midwife prescribers are referred to the publication *Decision-Making Framework for Nurse and Midwife Prescribing* (An Bord Altranais, 2007). This document outlines the decision-making pathway that should be followed by RNPs (see Appendix 6). In particular the pathway highlights that a fundamental step in the process is that:

The nurse/midwife documents the treatment plan including the prescribed medication, monitoring/evaluation and follow up care and ensures a continuing care/discharge plan is completed for the patient/service-user and communicated to the appropriate health care professional.

The *Decision-Making Framework for Nurse and Midwife Prescribing* (An Bord Altranais, 2007) also highlights the importance of the following in informing an RNP's decision to prescribe:

- Ensure that prescribing is within the nurse's/midwife's scope of practice and competency
- Prescribing is undertaken following an assessment of the patient/service-user
- The RNP has gathered evidence to determine a treatment plan for the patient/service-user
- The RNP has determined the required pharmacological/non-pharmacological treatment option(s) for the patient/service-user[4]
- The nurse/midwife initiates the treatment decision in discussion with and agreement by the patient/service-user (and/or carer if applicable) providing a comprehensive description of the treatment prescribed including expectations of treatment and side effects if any
- The RNP ensures that record keeping is accurate and up-to-date.

Associated competencies

Domain 1. Professional/Ethical Practice

1.3 Practices within a framework of professional accountability and responsibility in relation to prescribing.

Domain 2. Holistic Approaches to Care and Integration of Knowledge

2.2 Plans care in consultation with the patient/service-user taking into consideration the therapeutic regimes of all members of the interdisciplinary team.

[4] The RNP considers the choices of prescribing a medication, not prescribing a medication or altering a prescription.

Practice Standard 2. Communication and History Taking

The responsibility of prescriptive authority requires the RNP to effectively and efficiently communicate with the patient/service-user and to complete an accurate and comprehensive medication history.

Rationale

Communicating with a patient/service-user and comprehensive history taking are fundamental principles of safe and effective prescribing practice. The quality of the consultation between the RNP and patient/service-user is central to outcomes such as correct diagnosis, effective treatment, concordance, medication adherence, quality and safety. The complexity, depth of information and duration of a consultation is dictated by the individual patient's/service-user's needs; the underlying principle is that the information is sufficient to allow the RNP to formulate an appropriate plan of care.

A comprehensive medication history is important to reduce the possibility of prescribing errors associated with collecting incomplete medication histories (Tam et al, 2005). The types of medication history errors that may occur include (Tam, et al 2005; Fitzgerald, 2009):

- An error of omission – not recording or identifying a medication the patient/service-user is currently taking.
- An error of commission – incorrectly recording a medication that the patient/service-user was not using.
- Incorrect frequency – incorrectly recording the frequency with which the patient/service-user was taking medication.
- Incorrect dose - recording the incorrect dose of medication taken by the patient/service-user[5].

Guidance for Practice

There are a number of important areas that normally should be considered within the consultation. These include the following:

- Assess and clarify a patient's/service-user's clinical condition including an evaluation of their reason for presentation for treatment and the patient's/service-user's presenting symptoms.
- An appropriate physical examination should be carried out if clinically indicated.
- Assess the patient's/service-user's management of the presenting problem to date and whether they have experienced any previous episodes of the presenting problem.
- Undertake an assessment of the patient's/service-user's current and past medication history.
- Medication history should include an assessment of the following:
  - Medications currently prescribed
  - Over-the-counter medications (OTC). Patients/service-users may not recognise that medications they buy over the counter are important and may result in drug interactions. Patients/service-users may also be taking OTC medications inappropriately
  - Herbal remedies[6]
  - Homeopathic medicines
  - Medicines taken that have been prescribed for others
  - Dietary, vitamin or food supplements.

[5] RNPs are referred to the document published by the Department of Health and Children in 2008 entitled: *Building a Culture of Patient safety: Report of the Commission on Patient Safety and Quality Assurance.* In particular prescribers are referred to the section on medication reconciliation (section 7.5) which outlines a process that may be used to prevent errors of omission.

[6] There is evidence that herbal remedies and alternative medicines are infrequently if ever recorded in medication histories, however they can lead to drug interactions and adverse effects. See for example Fitzgerald (2009) Medication errors: the importance of an accurate drug history. *British Journal of Clinical Pharmacology* 67, (6), 671-675.

- The patient's/service-user's medication should be assessed both by asking the patient/service user and/or their family if appropriate[7] and reviewing the patient's/service user's chart and notes. Patients/service-users on multiple medications may not be aware of the name or dosage of their current regimen therefore it is good practice to check all available sources of information (WHO, 2009).
- Ask the patient/service-user or their family if appropriate **and** also refer to the patient's/service-user's file or chart for documented medication allergies, other forms of allergies, medication sensitivities and adverse drug reactions.
- Ask the patient/service user, if appropriate, about their level of adherence to their current medication regimen (Fitzgerald, 2009).
- Be aware of any precautions that need to be taken into consideration when prescribing, for example if the patient/service-user is pregnant or breastfeeding.
- Be aware of potential drug interactions with the patient's/service-user's existing condition such as diabetes and liver or kidney disease[8].
- When prescribing the RNP should take into account the issue of polypharmacy, the possibility of cognitive impairment and whether the patient/service-user has any associated co-morbidities (Agrawal et al, 2009).
- If relevant, order and review diagnostic, radiological and laboratory tests and interpret results in relation to provisional diagnosis and proposed treatment plan.
- Smoking, alcohol history and illicit drug use should also be considered due to the potential interaction between these substances and medication prescribed (Young, Duggan and Franklin, 2009).
- Social circumstances, occupational and family history are also important elements of a comprehensive medication history.
- Review the diagnosis in the context of the patient's/service-user's overall clinical and medication history and presentation.
- Take into consideration the patient's/service-user's overall care plan.

In the event there is a decision to prescribe a medication as part of the patient's/service- user's care plan, there are a number of principles that normally should be taken into account during the prescribing consultation process (Office of the Nursing Services Director, 2009a, 2009b; WHO, 2009; Beckwith and Franklin, 2007). These include:

- Only prescribe if the RNP has assessed the patient/service-user and the RNP has a valid clinical relationship with the patient/service-user.
- Communicate clearly with patients/service-users in a language that they understand. Patients and service-users should normally be provided with the following information:
  - A rationale for the prescription
  - Name of the medication
  - Purpose of the medication
  - Dose and frequency with which medication is to be taken
  - Route of administration
  - Additional medication instructions, for example to take medication with food, or discuss the potential interaction between the medication prescribed and alcohol
  - Possible side-effects of their medication
  - When to come back or what to do if they have a concern about their medication.
- Include and encourage patients/service-users to be actively involved in the prescribing process.
- Decide whether it is appropriate to prescribe, not to prescribe or alter medication.

[7] The patient's consent, privacy and confidentiality should be taken into account if discussing their medication with others.

[8] Relevant sources should be referred to in this regard. For example the patient's consultant or GP, hospital or community pharmacist, *British National Formulary, Summary Product Characteristics* and patient information leaflets.

- Monitor, if appropriate, the patient's/service-user's response to medication.

Associated competencies

Domain 2. Holistic Approaches to Care and Integration of Knowledge

2.1 Conducts a systematic holistic assessment of patient/service-user needs.

2.2 Plans care in consultation with the patient/service-user taking into consideration the therapeutic regimes of all members of the interdisciplinary team.

2.3 Implements planned nursing/midwifery care/interventions to achieve the identified outcomes of the plan of care.

2.4 Evaluates patient/service-user progress toward expected outcomes and review plans in accordance with evaluation data and consultation with the patient/service-user.

2.5 Demonstrates and integrates knowledge of medicinal products for safe medication management and prescribing practices.

Domain 3. Interpersonal Relationships

3.1 Establishes and maintains caring therapeutic interpersonal relationships with individuals/service-users/groups/ communities for safe and effective prescribing.

Domain 4. Organisation and Management of Care

4.1 Effectively manages the nursing/midwifery care of service-users/groups/communities.

Practice Standard 3. Documentation

The *Decision-Making Framework for Nurse/Midwife Prescribing* (An Bord Altranais, 2007) gives reference to systems of documentation for patient/service-user care and prescribing, e.g. patient/service-user case notes and medication administration records. Individual health service providers/employers may have specific policies for documenting care and prescribing practices (including requirements for clinical audit of practice). The consultation and referral requirements of the RNP should be noted in the CPA. RNPs are referred to the An Bord Altranais documents *Recording Clinical Practice Guidance to Nurses and Midwives* (An Bord Altranais, 2002) and midwives are referred to the document *Practice Standards for Midwives* (An Bord Altranais, 2010). The principles of documenting and recording the care delivered to patients/service-users outlined in these documents also pertain to the standards of recording that should occur within prescribing practice.

The depth and detail of information recorded in a consultation is dependent on the context, circumstances and individual characteristics of the patient/service-user. If the consultation is a first consultation (no previous medical record), a previous record but with new, unresolved or deteriorating symptoms or consultation after a prolonged period of time then a full comprehensive clinical assessment should be carried out and the detail should be recorded in the associated consultation documentation.

Rationale

It is the responsibility of RNPs to comprehensively record their prescribing consultation. This allows for the episode of care related to prescribing to be communicated to other healthcare professionals, keeps an accurate record of the consultation and ensures the safety of the patient/service-user (Office of the Nursing Services Director, 2008). The document *Guidance to Nurses and Midwives on Medication Management* (An Bord Altranais, 2007) addresses the importance of an interdisciplinary approach to medication management; this is especially critical in the role as a RNP. Reference is given to the prevalence and aetiology of prescribing and medication management errors, with poor communication and documentation being identified as key contributing causes. The prevention, detection and reduction of prescribing and medication errors should occur in collaboration amongst the healthcare team, as errors may reflect a system problem and may involve other professions and departments.

Guidance for Practice

- The RNP should document all prescribing decisions and actions. The context of all consultations should be described with reference to a patient's/service user's age, gender, primary condition and reason for presentation for treatment.
- All episodes of nurse and midwife prescribing should normally be recorded in the patient's/service-user's case notes[9, 10]. The rationale being to ensure that there is clear communication of treatment with medical and other healthcare professionals.
- Accurate and comprehensible communication is central to preventing prescribing errors. Therefore it is important that all written communication is legible, unambiguous and does not lead to misunderstanding between health professionals.
- Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated with a reason for the amendment. Correction fluids should not be used.
- An RNP making a referral or consulting with another member of the healthcare team should clearly identify, by name and title/position, the person in the record.
- Documentation of the prescribing consultation should occur during or immediately after the prescribing consultation.

[9] It should be noted that individual health service providers/employers may have specific policies for documenting care and prescribing practices

[10] The National Hospitals Office (2007: 18) *Code of Practice for Healthcare Records Management* recommends that: 'All records relating to the patient shall be kept in a unified healthcare record file. The structure shall facilitate documentation of the chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes. The structure shall also facilitate the monitoring of standards, audit, quality assurance and the investigation of complaints.'

- In exceptional circumstances it may be necessary to record the consultation retrospectively. However this retrospective consultation should not normally be later than 24hrs after the consultation. The first date and time recorded should reflect the date and time of the current entry not the past consultation. The record should clearly indicate that it is a retrospective entry with the date and time details of the original consultation also recorded.
- Retrospective entries should never be presented as concurrent entries. In the event of a case review or audit it is essential that reviewers can distinguish between concurrent and retrospective entries in order to establish accurate information on the sequence of events and assess the reliability of entries.
- Regular audit of documentation is an integral part of maintaining quality prescribing practice.

The following should normally be documented in the patient's/service-user's case notes:

- All entries should have both the date (day/month/year) and time (using the 24 hour clock) of the consultation recorded (National Hospitals Office, 2007). The date and time are important especially in instances where the patient's/service-user's care and/or condition is changing frequently.
- Patient/service-user information including the patient's/service-user's age/date of birth, gender, address and medical record number.
- The purpose of the consultation and rationale for decisions made in relation to medication therapy. This should include the rationale for either issuing the prescription, changing the current medication regime (including discontinuing medication) or a decision not to prescribe.
- Name of medication prescribed, discontinued, dose changed or alternatively medication recommended by the RNP to be bought over-the counter (OTC).
- Instructions and advice given by the RNP to the patient/service-user regarding their medication.
- Dose, frequency, route and for how long the medication should be taken.
- What the patient/service-user was told to do in the event of side-effects or deterioration in condition.
- Date and/or time of proposed review or record if no follow-up review is required.
- If follow-up review is required, record the outcome of the review and efficacy of medication prescribed.
- **Note:** Always document patient/service-user drug allergies or adverse drug reactions. If the patient/service-user has no known allergies this should also be documented.
- All consultations should be signed by the RNP. They should also include the RNPs name printed and An Bord Altranais Personal Identification Number.

Note: It is not necessary to duplicate information already recorded in the patient's/service-user's clinical notes however it is the responsibility of the individual RNP to ensure and indicate in the current consultation that they are aware of the patient's/service-user's medical history, drug allergies and current medication and that this information is up-to-date prior to prescribing medication (Beckwith and Franklin, 2007; Drennan et al. 2009).

Associated competencies

Holistic approaches to care and integration of knowledge

2.2 Plans care in consultation with the patient/service-user, taking into consideration the therapeutic regimes of all members of the interdisciplinary team.

3.2 Collaborates with all members of the health care team and documents relevant information.

Practice Standard 4. Prescription writing

Specific standards for prescription writing must be adhered to as required by legislation and the health service provider/employer (including drugs and therapeutics committee) policy. This also pertains to the safe keeping and accountability associated with prescription pads.

Medicines regulations pertaining to prescription writing by the RNP include:

- *Medicinal Products (Prescription and Control of Supply) Regulations, 2003 (S.I. 540 of 2003)*
- *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations, 2007 (S.I. 201 of 2007)*

In summary, these regulations require the prescription to:

- Be legible
- State the name of the person issuing it and include the registration number (PIN) assigned to the nurse by An Bord Altranais
- The prescription (including computer-generated prescriptions) must be in ink/indelible
- The prescription must be dated and signed by the RNP with her/his usual signature
- The full name and address of the patient/service-user must be on the prescription
- If a patient/service-user is under the age of 12 years, the date of birth is required.

Prescription writing for MDA-controlled drugs

Prescriptions for controlled drugs have additional requirements.

The RNP must handwrite:

- The name and address of the patient/service user
- The dose to be prescribed
- The form (in the case of preparations)
- The strength when appropriate and in both words and figures
- Either the total quantity of the drug or preparation, or the number of dosage units to be supplied.

A prescription for controlled drugs cannot be repeated but may be dispensed in instalments by the direction of the prescriber.

The *Misuse of Drugs (Amendment) Regulations, 2007 (S.I. 200 of 2007)* states the particular requirements that must be met for a RNP to issue a prescription for Schedule 4 and 5 MDAs and a named Schedule 2 or 3 MDA drug. A new MDA schedule – Schedule 8 - has been devised for the specific purpose of providing a detailed listing of the drugs, route of administration and condition for which the Schedule 2 or 3 medication can be prescribed by the RNP. (Refer to Appendix 2 for Schedule 8).

The RNP has no legal authority to prescribe any other Schedule 2 or 3 MDA which is not listed on Schedule 8, nor write for a different route of administration of the named drug, nor prescribe for any condition/situation not named in the Schedule.

Health service provider/employer policies for nurse prescribing of Schedule 2 and 3 MDAs must be in adherence with Schedule 8 of the *Misuse of Drugs (Amendment) Regulations 2007*. Additional conditions may be attached by the health service provider/employer. The RNP must adhere to the relevant Misuse of Drugs Acts and Regulations for prescription of Schedule 4 and 5 MDAs.

Rationale

Prescription writing is an important component of the role of the RNP. A prescription is primarily an instruction from a prescriber to a dispenser and as such should be clear, legible and indicate precisely the treatment prescribed (WHO, 1994). This will ensure that the possibility of errors occurring is reduced and that

patients/service-users have a good understanding of the treatment prescribed. The RNP must adhere to legal requirements for prescription writing of scheduled prescription medicines and MDA controlled drugs. A prescription for a scheduled medication, including MDAs, must be correctly and accurately written, as it may otherwise result in difficulties for dispensing of the prescribed medication by the pharmacist and/or supply and administration to the patient/service-user.

Guidance for Practice

- It is recommended that the generic or non-proprietary name of the medication be used on the prescription. However, it is acknowledged that with some medications the proprietary name may need to be used.
- When recording the strength/dosage of the medication it is recommended that internationally and nationally accepted abbreviations only be used (see appendix 3). It is also good practice to identify the maximum daily dose of the medication.
- It is good practice to identify when the medication should be discontinued or if long-term medication is prescribed a review date should be indicated.
- It is important to ensure that the instructions regarding the medications are understood and agreed by the patient/service-user.
- The prescription should normally be written and signed in black ink – it is important that the RNP ensures that the written prescription is legible on all copies, including photostats related to the prescription.
- Corrections must only be made by re-writing the prescription. Use of correction fluid or deleting with a pen is not acceptable.

Associated competencies

Professional/ethical practice

1.3 Practices within a framework of professional accountability and responsibility in relation to prescribing.

Holistic approaches to care and integration of knowledge

2.5 Demonstrates and integrates knowledge of medicinal products for safe medication management and prescribing practices.

Interpersonal relationships

3.2 Collaborates with all members of the health care team and documents relevant information.

Practice Standard 5. Prescribing for self, family and significant others

Prescribing for self, family and/or significant others is not acceptable professional practice. There should be an established nurse/midwife to patient/service-user relationship when prescribing for another individual. A blurring of professional and personal boundaries of care and accountability results and represents a conflict of interest. Writing and issuing a prescription for personal use or for a family member or significant other must not be undertaken by the RNP, regardless of circumstances.

The individual requiring a prescribed medication should be referred to/directed to another appropriate registered prescriber (e.g. family general practitioner) or where health services are provided.

Rationale

Prescribing must take place in the context of providing nursing/midwifery care to an identified patient/service-user requiring the services of the health service provider. The medicines regulations - *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations, 2007* and *Misuse of Drugs (Amendment) Regulations, 2007* - provide specific requirements for nurses to issue a prescription which must be adhered to in the provision of health care. A RNP prescribing for self, family and significant others is in violation of these regulations.

Ethically, prescribing in this manner is not objective and is not best practice. Serious concerns may arise about the misuse/abuse of medicinal products and inappropriate prescribing.

Associated competencies

Professional/ethical practice

1.1 Practices in accordance with legislation and professional guidance affecting nursing/midwifery practice.

1.3 Practices within a framework of professional accountability and responsibility in relation to prescribing.

Practice Standard 6. Repeat prescribing

The RNP should be knowledgeable of the medicines regulations relating to the supply/dispensing of medications in instalments for the duration of individual prescriptions. Repeat prescribing may arise in situations where the original issued prescription was issued by another prescriber and the patient/service-user requests or requires a continued course of medication. This may typically occur in the treatment of chronic health conditions.

In these instances of repeat prescribing for continued treatment, the RNP should have a valid relationship with the patient/service-user and undertake an appropriate assessment of the need for continued treatment with the prescribed medication. This decision-making should be documented. It should include a discussion with the patient/service-user of perceived effectiveness and adherence to the treatment plan.

The RNP should acknowledge her/his scope of practice for prescribing, recognising any limitation of competence/knowledge and refer the patient/service-user to the appropriate practitioner for evaluation concerning the repeat prescription if required.

Rationale

There should be regular review and appropriate clinical assessment of the patient/service-user condition for continuing a specific medication in accordance with the overall treatment plan. Although the RNP may not have determined the initial need/diagnosis warranting the medication prescription, she/he is responsible for conducting a relevant assessment and decision in determining the appropriateness of a repeat/continued prescription. The issue of timely and appropriate medication review has been identified as a significant factor in ensuring patient/service-user safety and appropriate prescribing.

Associated competencies

Holistic approaches to care and integration of knowledge

2.1 Conducts a systematic holistic assessment of patient/service-user needs.

2.4 Evaluates patient/service-user progress toward expected outcomes and reviews plans in accordance with evaluation data and consultation with the patient/service-user.

2.5 Demonstrates and integrates knowledge of medicinal products for safe medication management and prescribing practices.

Practice Standard 7. Prescribing of unauthorised and off-label medications

Unauthorised medications[11]

The *Medicinal Products (Control of Placing on the Market) Regulations, 2007-2010* provide statutory authority for a medical practitioner to treat a patient under her/his care, using unauthorised (known as exempted) medicinal products. It does not extend this authority to a RNP to issue a prescription for unauthorised medication. This action is outside the nurse's/midwife's scope of practice for prescriptive authority. A patient/service user need for a prescription for an unauthorised medication should be referred to the appropriate medical practitioner.

Off-label medications[12]

The Department of Health and Children reviewed the relevant medicines legislation in relation to off label medication prescribing and advised An Bord Altranais that there is no impediment in the relevant legislation and regulations to prevent a RNP to prescribe an authorised medicinal product for an unauthorised indication. (i.e. off label). The issuing of a prescription for an unauthorised indication for an authorised medication must be in accordance with Regulation 5A of the *Medicinal Products (Prescription and Control of Supply) Regulations 2003* as amended.

Rationale

The prescribing of unauthorised medications by the RNP is not provided for in the current medicines regulations. The RNP is legally and professionally accountable and responsible for prescribing practices as mandated by the medicines legislation and the professional standards established by An Bord Altranais.

Off label prescribing as defined above is not prohibited by the medicines regulations. The *Medicinal Products (Control of Placing on the Market) Regulations 2007* as amended, do not prohibit the sale, supply, manufacture, possession or procuring the sale, supply, manufacture of an authorised medicinal product for an unauthorised indication. It is permissible for an authorised medication to be supplied from a prescription issued by any prescriber, including where the medication is to be used for an unauthorised indication.

Guidance for Practice

In tandem with the legislative requirements the RNP should be aware of best practice guidance and organisational policy in considering whether to prescribe an off label medication. As with all decisions in prescribing of medications for patients and service users the use of off-label medications must be within the RNP's scope of prescribing practice.

The RNP should be knowledgable of best practice for prescribing an authorised medication for an unauthorised indication. This includes determining:

- if there is an alternative licensed medication that could be prescribed;
- if the medication is regularly used to treat patient/service users in the RNP's area of clinical practice
- the listing of the specific medication within the health service provider's prescribing formulary and/or guidelines.

Newly authorised medications and medications being used in clinical trials should not be considered for unauthorised indication use by the RNP. The RNP should review the inclusion of any authorised medication to be used for an unauthorised indication for Attachment B (medication listing) of the CPA with the Collaborating Medical Practitioner(s) and the Drug and Therapeutic Committee. The health service provider's organisational

[11] 11 An unauthorised (exempt) medication has not been the subject of a marketing authorisation, certificate of registration or approved for licensing as per the Irish Medicines Board or the European Medicines Evaluation Agency

[12] Off label means the use of an authorised medication outside the terms of its product authorisation, e.g.. use for an indication; dose; specific patient population or a specific age-group which is not specified in the authorised product information/summary of product characteristics (SPC)

policy for nurse/midwife prescribing should detail the process for reviewing and approving the use of authorised medications for unauthorised indications by a RNP.

The *HSE RNP Guidance Process for Off Label Medications* (Office of the Nursing and Midwifery Services Director, 2010) provides RNPs and health service employers with a detailed template as a guide for the governance structures required for the implementation of off label prescribing by RNPs. An Bord Altranais supports the use of this template (or a similar tool) for all nurses and midwives with prescriptive authority to ensure the safety and quality of care for patients and service users requiring an off label medication for a clinical indication.

Associated competencies

Professional/ethical practice

1.1 Practices in accordance with legislation and professional guidance affecting nursing/midwifery practice.

1.2 Practices within the limits of own competence and takes measures to develop and maintain own competence.

1.3 Practices within a framework of professional accountability and responsibility in relation to prescribing.

Practice Standard 8. Prescribing by means of verbal/telephone, email or fax

Issuing or communicating a prescription by verbally, telephone, email or fax is not considered acceptable prescribing practice for a RNP and should not be conducted under any circumstance. The prescription for a medicinal product must be documented in writing, as required by the medicines regulations and health service provider/employer. Practice standard 4 should be adhered to.

Rationale

The medicines regulations of 2007 for both prescription and MDA drugs do not authorise the RNP to prescribe medications employing means of communication other than in writing. An Bord Altranais does not support the use of verbal, telephone, email or fax medication orders as routine medication management practice for communication of an individual patient/service-user prescription.

Associated competencies

Professional/ethical practice

1.1 Practices in accordance with legislation and professional guidance affecting nursing/midwifery practice.

1.2 Practices within the limits of own competence and takes measures to develop and maintain own competence.

Practice Standard 9. Separation of responsibilities in the medication management cycle

a. Separation of prescribing and supplying/administering of medications

The RNP should separate the activity of prescribing a medication and the subsequent actions of supplying and/or administering the medication. Another individual should undertake the supply/administration component of the medication management cycle, especially in the case of MDA drugs. This is safe practice, providing for the typical safety checks within the medication management cycle.

Whilst acknowledging the fundamental principles associated with the separation of responsibilities for prescribing and supplying/administering medications, the local site specific CPA may outline situations where the RNP may in fact be involved in a cross over and merging of these activities as part of her/his provision of patient/service-user care. The CPA should provide for the auditing of such practices as part of the overall audit of prescriptive practices.

b. Separation of prescribing and dispensing

The RNP should not undertake to both prescribe and dispense the medication as part of providing episodes of patient/service-user care. There should be clear separation of these activities. There may be circumstances arising when the RNP may be required to supply a medicine without previous dispensing of the medicinal product by a pharmacist. In these situations, the prescriber should be aware of her/his responsibilities with this practice in the overall management of medications.

Whilst recognising the separation of responsibilities for prescribing and dispensing medication as a fundamental principle, the local site specific CPA may outline situations where the RNP may in fact be involved in a cross over and merging of these activities as part of her/his provision of patient/service-user care. The CPA should provide for the auditing of such practices as part of the overall audit of prescriptive practices.

Rationale

Best practice advocates the separation of responsibilities in the systems associated with medication management. The pharmacist has a particular role and expertise for dispensing, as does the nurse/midwife involved with supply and/or administration of medications, particularly in acute care settings. Distinct separation of responsibilities and activities in the medication management cycle provides for greater patient/service-user safety and error prevention.

Associated competencies

Holistic approaches to care and integration of knowledge

2.5 Demonstrates and integrates knowledge of medicinal products for safe medication management and prescribing practices.

Interpersonal relationships

3.2 Collaborates with all members of the health care team and documents relevant information.

Organisation and management of care

4.1 Effectively manages the nursing/midwifery care of service-users/groups/communities.

Practice Standard 10. Influence of outside interests (relationships with pharmaceutical representation or similar organisations)

The RNP should prescribe in an appropriate, ethical manner, based on the best interests of the patient/service-user only. She or he should not be influenced by factors such as financial support by pharmaceutical and/or health care interests.

Rationale

The *Code of Professional Conduct for each Nurse and Midwife* (An Bord Altranais, 2000) states:

"The nurse should not accept any gifts or favours from patients/service-users which could be reasonably be interpreted as seeking to exert undue influence or to obtain preferential treatment." Although this specifically refers to patients/service-users, it should be read as incorporating other influencing interests.

The *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais, 2000) refers to the values of nursing and midwifery practice and the relationship to the patient/service-user based on trust, understanding, compassion and support. Nursing/midwifery practices should always be based on the principles identified within the Code of Professional Conduct.

Associated competencies

Professional/ethical practice

1.1 Practices in accordance with legislation and professional guidance affecting nursing and midwifery practice.

Personal and professional development

5.1 Acts to enhance the personal and professional development of self and others.

Practice Standard 11. Continuing professional development and continued competency

An Bord Altranais, through its Requirements and Standards for the Education Programme for Nurses and Midwives with Prescriptive Authority (2007) and professional guidance, states its standard of the RNP's professional and personal responsibility to maintain individual competency for prescribing practice. There is an obligation for the RNP to commit to, and engage in, continuing professional development relating to assurance of competency for her/his prescribing practices. This is affirmed in the CPA.

Health service providers/employers have a responsibility to provide support and access to continuing professional development and assessment of competence. The CPA signed by the RNP, medical practitioner and the health service provider/employer requires the involved parties to be aware of the professional regulatory and organisational requirements for the RNP's continued competence for maintaining prescriptive authority.

Rationale

Competence is the ability of the RNP to practice safely and effectively and fulfil her/his professional responsibility for prescriptive authority within her/his scope of practice (An Bord Altranais, 2007). The RNP accepts personal responsibility for professional development and the maintenance of professional competence. This is achieved by engaging in continuing professional development, audit of practice, and peer review.

Upon entry to the division of the Register for Nurse Prescriber, it is acknowledged that the applicant has attained the competencies of prescriptive authority through the completion of the education programme. She/he has been deemed competent to prescribe as per the Higher Education Institutions Marks and Standards for the theoretical and clinical elements of the programme.

Associated competencies

Organisation and management of care

4.1 Effectively manages the nursing/midwifery care of service-users/groups/communities.

Personal and professional development

5.1 Acts to enhance the personal and professional development of self and others.

References

Agrawal A. et al. (2009) Medication errors: problems and recommendations from a consensus meeting. *British Journal of Pharmacology* 67 (6), 592-598

An Bord Altranais, (2010) *Nurses Rules, (2010),* An Bord Altranais, Dublin

An Bord Altranais, (2010) *Practice Standards for Midwives,* An Bord Altranais, Dublin

An Bord Altranais, (2007) *Collaborative Practice Agreement for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin

An Bord Altranais, (2007) P*ractice Standards for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin

An Bord Altranais, (2007) *Decision-Making Framework for Nurse and Midwife Prescribing,* An Bord Altranais, Dublin

An Bord Altranais, (2007) *Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority,* An Bord Altranais, Dublin

An Bord Altranais, (2007) *Guidance to Nurses and Midwives on Medication Management,* An Bord Altranais, Dublin

An Bord Altranais, (2002) *Recording Clinical Practice - Guidance to Nurses and Midwives,* An Bord Altranais, Dublin

An Bord Altranais, (2000) *Scope of Nursing and Midwifery Practice Framework,* An Bord Altranais, Dublin

An Bord Altranais, (2000) *The Code of Professional Conduct for each Nurse and Midwife,* An Bord Altranais, Dublin

Australian Commission on Safety and Quality in Healthcare, (2006) *National Terminology, Abbreviations and Symbols to be used in the Prescribing and Administering of Medicines in Australian Hospitals.* Australian Commission on Safety and Quality in Healthcare, Darlinghurst

Barber N. (1995) What constitutes good prescribing? *British Medical Journal* 310: 923-925.6

Beckwith S. and Franklin P. (2007) *Oxford Handbook of Nurse Prescribing.* OUP Oxford

Drennan J., Naughton C., Allen D., Hyde A., O'Boyle K., Felle P., Treacy P., and Butler M. (2009) *Independent Evaluation of the Nurse and Midwife Prescribing Initiative.* University College Dublin, Dublin

Fitzgerald R. J. (2009) Medication errors: the importance of an accurate drug history. *British Journal of Clinical Pharmacology* 67, (6), 671-675)

Government of Ireland (2007) *Misuse of Drugs (Amendment) Regulations (2007), Statutory Instruments No. 200 of (2007).* Dublin: Stationery Office

Government of Ireland (2007) *Medicinal Products Prescription and Control of Supply (Amendment) Regulations (2007) (SI No. 201 of (2007)).* Dublin: Stationery Office

Department of Health and Children, (2008) *Building a Culture of Patient Safety - Report of the Commission on Patient Safety and Quality Assurance,* Stationery Office, Dublin

Government of Ireland, (2006) *Irish Medicines Board (Miscellaneous Provisions) Act 2006 (No.3 of 2006)* Stationery Office, Dublin

Health Service Executive, (2010) *Health Service Executive Code of Practice for Healthcare Records Management: Abbreviations,* HSE, Dublin

Institute for Safe Medication Practices, (2004) *List of Error-Prone Abbreviations, Symbols and Dose Designations.* ISMP (Accessed at:http://www.ismp.org/tools/errorproneabbreviations)

Latter S., Maben J., Myall M., and Young A. (2007) Evaluating nurse prescribers' education and continuing professional development for independent prescribing practice: Findings from a national survey in England. *Nurse Education Today* 27, 685-69

National Hospitals Office, (2007) *Code of Practice for Healthcare Records management; Version 2*. NHO, Dublin

National Prescribing Centre, (2007) – see www.npc.org

Office of the Nursing Services Director, (2009a) *National Policy for Nurse and Midwife Medicinal Product Prescribing in Acute Hospitals.* Health Service Executive, Dublin

Office of the Nursing Services Director, (2009b) *National Policy for Nurse and Midwife Medicinal Product Prescribing in Primary, Community and Continuing Care.* Health Service Executive, Dublin

Tam V., Knowles S., Cornish P., Fine N., Marchesano R., and Etchells E. (2005) Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. *JAMC*, 173 (5), 510 – 515

World Health Organisation, (2009) *WHO Patient Safety: Curriculum Guide for Medical Schools.* WHO, Geneva

World Health Organisation, (1994) *Guide to Good Prescribing: A Practical Manual.* WHO, Geneva

Young K., Duggan L., and Franklin P. (2009) Effective consulting and history-taking skills for prescribing practice. *British Journal of Nursing* 18, (17), 1056-1061

Appendix 1

Competencies for Prescriptive Authority

Domain 1. Professional/Ethical Practice

Performance Criteria:	Indicators:
1.1 Practices in accordance with legislation and professional guidance affecting nursing/midwifery practice	• Practices within the legislation and professional regulation and guidelines relevant to his/her scope of practice and care setting • Integrates accurate and comprehensive knowledge of ethical principles and the Code of Professional Conduct within the scope of professional practice in the delivery of nursing/midwifery care involving medicinal products and prescribing • Accepts personal accountability for prescribing decisions and actions, understanding the legal implications of doing so
Performance Criteria:	**Indicators:**
1.2 Practices within the limits of own competence and takes measures to develop and maintain own competence	• Recognises own abilities and level of professional competence • Conducts self audit of practice incorporating reflective practice/thinking to identify prescribing competence within the nurse/midwife's scope of practice • Maintains current knowledge of advances in practice, pharmacotherapeutics and emerging safety concerns related to prescribing • Consults appropriately with medical practitioner and/or pharmacist for patient/service-user[1] when individual nurse/midwife perceives limitations in his/her knowledge of prescribing • Identifies a mechanism to support continuing professional development needs
Performance Criteria:	**Indicators:**
1.3 Practices within a framework of professional accountability and responsibility in relation to prescribing	• Adheres to legislation, professional regulation and guidelines and employing organisations standards/policies for prescriptive authority • Complies with the requirements/policies of the employing organisation for: - reporting medication errors/incidents and near misses - audit of prescribing patterns/practices • Complies with the requirements of the employing organisation and the Irish Medicines Board for reporting adverse drug reactions • Understands and applies the mechanisms of the HSE National Shared Services Primary Care Reimbursement Service for prescribing

[1]The term patient/client also means patient/service-user

Domain 2. Holistic Approaches to Care and Integration of Knowledge

Performance Criteria:	Indicators:
2.1 Conducts a systematic holistic assessment of patient/service-user needs	• Performs a comprehensive assessment of the patient/service-user encompassing history taking, physical examination and identification of health risk factors • Comprehends the health conditions[2] being managed, their natural progress and how to assess the severity of condition • Assesses the relationship between health condition and current medication plan • Requests and interprets relevant diagnostic tests and procedures to inform appropriate and safe prescribing • Evaluates the use of complementary therapies by the patient/service-user for safety and potential interactions
Performance Criteria:	**Indicators:**
2.2 Plans care in consultation with the patient/service-user taking into consideration the therapeutic regimes of all members of the interdisciplinary team	• Critically utilises assessment data with expert clinical decision-making skills to formulate a diagnosis and plan of care based on scientific rationale, evidence based standards of care and practice guidelines supporting the maintenance and promotion of health • Integrates appropriate non-pharmacologic interventions into a plan of care and advises the patient/service-user on the use of such interventions • Involves patient/service-user or carer as active participants in decision-making process and plan of care that is mutually agreed • Initiates appropriate and timely consultation and/or referral when the problem exceeds the nurse/midwife's scope of practice and expertise
Performance Criteria:	**Indicators:**
2.3 Implements planned nursing/midwifery care/interventions to achieve the identified outcomes of the plan of care	• Implements care based on knowledge, skills and competence within his/her scope of practice • Considers appropriate diagnostic and therapeutic interventions as part of ongoing plan of care • Provides guidance and advice regarding the agreed care/interventions to the patient/service-user
Performance Criteria:	**Indicators:**
2.4 Evaluates patient/service-user progress toward expected outcomes and review plans in accordance with evaluation data and consultation with the patient/service-user	• Evaluates and provides evidence based rationale for clinical decision and nursing/midwifery intervention with regard to pharmacological/nonpharmacological treatment choice or referral to medical practitioner if applicable • Schedules appropriate follow-up care to monitor the patient/service-user and evaluate their response to treatment

[2]also includes issues of health promotion and prevention

Performance Criteria:	Indicators:
2.5 Demonstrates and integrates knowledge of medicinal products for safe medication management and prescribing practices	• Integrates accurate and comprehensive knowledge of the Guidance to Nurses and Midwives on Medication Management within the scope of professional practice in the delivery of nursing/midwifery care involving medicinal products and prescribing • Identifies and utilises current medicinal products information in the provision of individualised care • Utilises expert knowledge of pharmacokinetics and pharmacodynamics to determine appropriate dosage, dosage form, route and frequency of administration of medications based on relevant individual patient/service-user characteristics (i.e. age, gender, co-morbidity, culture) • Identifies and integrates appropriate monitoring systems for medication safety and efficacy in the care plan • Demonstrates an understanding of the potential for unwanted effects, (e.g. adverse drug reactions [ADRs], drug interactions, special precautions and contraindications), and actions to avoid/minimise and manage them • Understands the potential for misuse of drugs • Applies the principles of evidence-based practice, and clinical and cost-effectiveness • Recognises the public health issues related to medicinal product use • Considers non-pharmacological approaches to modifying disease and promoting health where appropriate

Domain 3. Interpersonal Relationships

Performance Criteria:	Indicators:
3.1 Establishes and maintains caring therapeutic interpersonal relationships with individuals/service-users/groups/ communities for safe and effective prescribing	• Discusses with patient/service-user assessment findings and treatment options recognising relevant individual patient/service-user characteristics (i.e. age, gender, co-morbidity, culture) and expectations • Assesses the patient/service-user understanding of and own responsibility in their care plan, involving carers where appropriate • Facilitates the patient/service-user in self management of condition and prescribed treatment • Communicates sensitively, respecting patient/service-users' emotions and concerns

Performance Criteria:	Indicators:
3.2 Collaborates with all members of the health care team and documents relevant information	• Identifies the roles and responsibilities of other health care professionals in the prescribing process • Establishes relationships with other health care professionals based on understanding and mutual respect • Maintains comprehensive documentation and patient/service-user records of plan of care within a legal and ethical framework

	• Participates in interdisciplinary team collaboration relating to the patient/service-user's care plan • Establishes mechanisms for consultation regarding practice decisions and referral pathways

Domain 4. Organisation and Management of Care

Performance Criteria:	Indicators:
4.1 Effectively manages the nursing/midwifery care of service-users/groups/communities	• Demonstrates quality assurance and quality management in prescribing through a structure of audit and report • Integrates the principles of clinical risk management and health and safety in prescribing practice • Identifies health promotion priorities and implements health promotion strategies for patient/service-user groups in the area of clinical practice

Domain 5. Personal and Professional Development

Performance Criteria:	Indicators:
5.1 Acts to enhance the personal and professional development of self and others	• Demonstrates a commitment to life-long learning • Accepts personal responsibility for professional development and the maintenance of professional competence • Maintains current knowledge of advances in scope of practice associated with prescribing and medication management • Develops professional links with others practising in the same specialist area • Informs and empowers patients/service-users and communities to protect, maintain and promote health • Contributes to the learning experience of colleagues through support, supervision and teaching in medication management • Contributes to professional and health policy at local, regional and national level in promoting safe and effective medication practices • Uses the outcomes of audit of prescribing practices to improve service provision

Appendix 2

Schedule 8 Drugs which Practitioners who are Registered Nurse Prescribers may Prescribe within MDA Schedules 2 and 3

PART 1 - Drugs for pain relief in hospital

I. for the pain relief of a person in a hospital in respect of probable myocardial infarction,

II. for the relief of the acute or severe pain of a person in a hospital after trauma,

or

for the post-operative pain relief of a person in a hospital who has had either condition described in I or II.

DRUG	ROUTE OF ADMINISTRATION
morphine sulphate	oral, intravenous, intramuscular
codeine phosphate	oral

PART 2 - Drugs for palliative care

DRUG	ROUTE OF ADMINISTRATION
morphine sulphate	oral, subcutaneous
hydromorphone	oral, subcutaneous
oxycodone	oral, subcutaneous
buprenorphine	transdermal
fentanyl	transmucosal, transdermal
methylphenidate	oral
codeine phosphate	oral

PART 3 - Drugs for purposes of midwifery

DRUG	ROUTE OF ADMINISTRATION
pethidine	intramuscular

PART 4 - Drugs for neonatal care in hospital

DRUG	ROUTE OF ADMINISTRATION
morphine sulphate	oral, intravenous
fentanyl	intravenous

Appendix 3

Use of Abbreviations

A major cause of medication error is the incorrect use of abbreviations and dosages. Abbreviations are at risk of being misunderstood not only by the patient/service-user but also by those responsible for dispensing the medication. If abbreviations are used in prescribing practice they should only be those that are in common usage in the health services in Ireland. RNPs are referred to the document *Health Service Executive Code of Practice for Healthcare Records Management: Abbreviations* (Health Service Executive, 2010). This document provides guidance on the appropriate use of abbreviations in the delivery of healthcare and should be referred to in conjunction with prescribing practice.

It is important to note that the following are guidelines and examples of best practice in the use of abbreviations. It is not intended as a complete listing.

Guidance for Practice

The following guidelines are recommended when documenting the prescribing process and completing a prescription (HSE, 2010; Australian Commission on Safety and Quality in Healthcare, 2006; Institute for Safe Medication Practices, 2004):

- It is recommended that medication names be never abbreviated. Medication names should be written in full.
- Medications should normally be prescribed using the approved generic name.
- Print all text - especially medication names.
- When documenting dose the following is recommended (Australian Commission on Safety and Quality in Healthcare, 2006):
  a. Use words or the Hindu-Arabic number system, i.e. 0, 1, 2, 3, 4, 5, 6, 7, 8, 9. Roman numerals should not be used as they can lead to medication errors. For example do not use ii for two, iii for three, iv for four etc.
  b. Use metric units (e.g. micrograms, milligrams, grams). Do not use apothecary units (e.g. grains, minims or drams,).
  c. Place a zero (known as a leading zero) in front of a decimal point for a dose less than 1, for example use 0.5 not .5 Do not use trailing zeros, for example use 2 mg not 2.0 mg. Quantities less than 1 gram should be written in milligrams, e.g. 500mg, not 0.5g. Quantities less than 1 milligram should be written in micrograms e.g. 100 micrograms not 0.1mg. When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g. 0.5ml not .5ml. The use of the decimal point is only acceptable to express a range, e.g. 0.5 to 1g.
  d. When stating dosage frequency it is important to be clear, for example use 'three times a week' not 'three times weekly' as the latter could be confused as 'every three weeks'.
- Avoid fractions, for example - 1/7 could be interpreted as 'for one day', 'once daily', 'for one week' or 'once weekly' - 1/2 could be interpreted as 'half' or as 'one to two'.
- Do not abbreviate the following: International Units, Micrograms, Nanograms.
- Do not use the unit cubic centimetre, or the abbreviations c.c. or cm^3 to denote millilitres.
- Always specify the dose, route and frequency.
- Directions must generally be in English without abbreviations (exceptions listed below):
  - b.d./b.i.d. - Twice daily

- Mane - In the morning
- Nocte - At night
- p.r.n. - When required
- q.d.s./q.i.d. - Four times daily
- STAT - Immediately
- Tarde - In the evening
- t.d.s./t.i.d. - Three times daily

- In the case of medications that are being prescribed at particular hourly frequencies, the only acceptable way of writing these are:
  - 12 hourly or twelve hourly or every 12 hours or every twelve hours
  - 4 hourly or four hourly or every 4 hours or every four hours
  - No other method of expressing this dosage is acceptable including q12h, 120, q4h, q.q.h., 40. In particular a superscript 0 to indicate hourly should never be used as it may be mistaken for a zero.
- In the case of preparations to be taken "as required", always specify the minimum dose interval e.g. Paracetamol tablets 500mg 2 every 6 hours p.r.n.
- OD or o.d for once a day should not be used. Use "daily" instead (ISMP, 2004).
- Days of the week must not be abbreviated but must always be written in full. For drugs to be administered only on specific days of the week then those days must always be written in full.
- The following abbreviations may be used for routes of administration:
  - IV – Intravenously
  - IM – Intramuscularly
  - Ng – Nasogastric
  - PEG - Percutaneous Endoscopic Gastrostomy
  - PO - Per Oral (i.e. oral by mouth)
  - PV- Per Vaginal
  - SC – Subcutaneously
  - PR - Per Rectum
  - SL - Sublingually

Abbreviations should not be used for other routes. Instead write the term in full, e.g. intradermally, intrathecally, intraperitoneally, transdermally, intraosseouslly or endotracheally.

Appendix 4

Legislation, Guidelines, Policies and Standards

This document should be consulted in association with the following legislation, guidelines, policies and standards:

- An Bord Altranais (2000) *Review of Scope of Practice for Nursing and Midwifery: Final Report.* An Bord Altranais, Dublin.
- An Bord Altranais (2000) *The Code of Professional Conduct for each Nurse and Midwife.* An Bord Altranais, Dublin.
- An Bord Altranais (2000) *Scope of Nursing and Midwifery Practice Framework.* An Bord Altranais, Dublin.
- An Bord Altranais (2002) *Recording Clinical Practice - Guidance to Nurses and Midwives.* An Bord Altranais, Dublin.
- An Bord Altranais (2007) *Guidance to Nurses and Midwives on Medication Management.* An Bord Altranais, Dublin.
- An Bord Altranais (2007) *Requirements and Standards for the Education Programme for Nurses and Midwives with Prescriptive Authority.* An Bord Altranais, Dublin.
- An Bord Altranais (2007) *The Decision-Making Framework for Nurse/Midwife Prescribing.* An Bord Altranais, Dublin.
- An Bord Altranais (2007) *Collaborative Practice Agreement for Nurses and Midwives with Prescriptive Authority.* An Bord Altranais, Dublin.
- An Bord Altranais (2009) *Professional Guidance for Nurses Working with Older People.* An Bord Altranais, Dublin.
- An Bord Altranais (2010) *Practice Standards for Midwives.* An Bord Altranais, Dublin.
- An Bord Altranais (2010) *Nurses Rules 2010.* An Bord Altranais, Dublin.
- Health Service Executive (2009) *National Policy for Nurse and Midwife Medicinal Product Prescribing in Acute Hospitals.* Health Service Executive, Dublin.
- Health Service Executive (2009) *National Policy for Nurse and Midwife Medicinal Product Prescribing in Primary, Community and Continuing Care.* Health Service Executive, Dublin.
- *Irish Medicines Board (Miscellaneous Provisions) Act, 2006* (Commencement) Order 2007. Stationery Office, Dublin.
- *Irish Medicines Board (Miscellaneous Provisions) Act, 2006* (Section 16 I (ii)). Stationery Office, Dublin.
- *Medicinal Products (Prescription and Control of Supply) Regulations 2003* Stationery Office, Dublin.
- *Medicinal Products (Licensing and Sale) Regulations 1998* Stationery Office, Dublin.
- *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007.* Statutory Instruments No. 201 of 2007. Stationery Office, Dublin. Medicinal Products (Control Of Advertising) Regulations 2007 SI 541. Stationery Office, Dublin.
- *Medicinal Products (Control Of Placing On The Market) Regulations 2007 SI 540 of 2007.* Stationery Office, Dublin.
- *Misuse of Drugs Regulations 1998* Stationery Office, Dublin.
- *Misuse of Drugs (Amendment) Regulations 1993* Stationery Office, Dublin.

- *Misuse of Drugs (Amendment) Regulations 2007.* Statutory Instruments No. 200 of 2007. Stationery Office, Dublin.
- National Hospitals Office (2007) *Code of Practice for Healthcare Records Management: Version 2.* National Hospitals Office. Dublin.
- National Hospitals Office (2010) *National Hospitals Office Code of Practice for Healthcare Records Management: Abbreviations.* National Hospitals Office. Dublin.
- Office of the Nursing Services Director, Health Service Executive (2008) *Guiding Framework* for the Implementation of Nurse and Midwife Prescribing in Ireland. Health Service Executive, Dublin.
- Office of the Nursing Services Director, Health Service Executive (2008) *Patient and Service User Information Leaflet.* Health Service Executive, Dublin.
- Office of the Nursing Services Director, Health Service Executive (2008) *Nurse and Midwife Data Collection System.* Health Service Executive, Dublin.
- Office of the Nursing Services Director, Health Service Executive (2008) *An Introduction to the Audit of Nurse and Midwife Prescribing.* Health Service Executive, Dublin.

Appendix 5

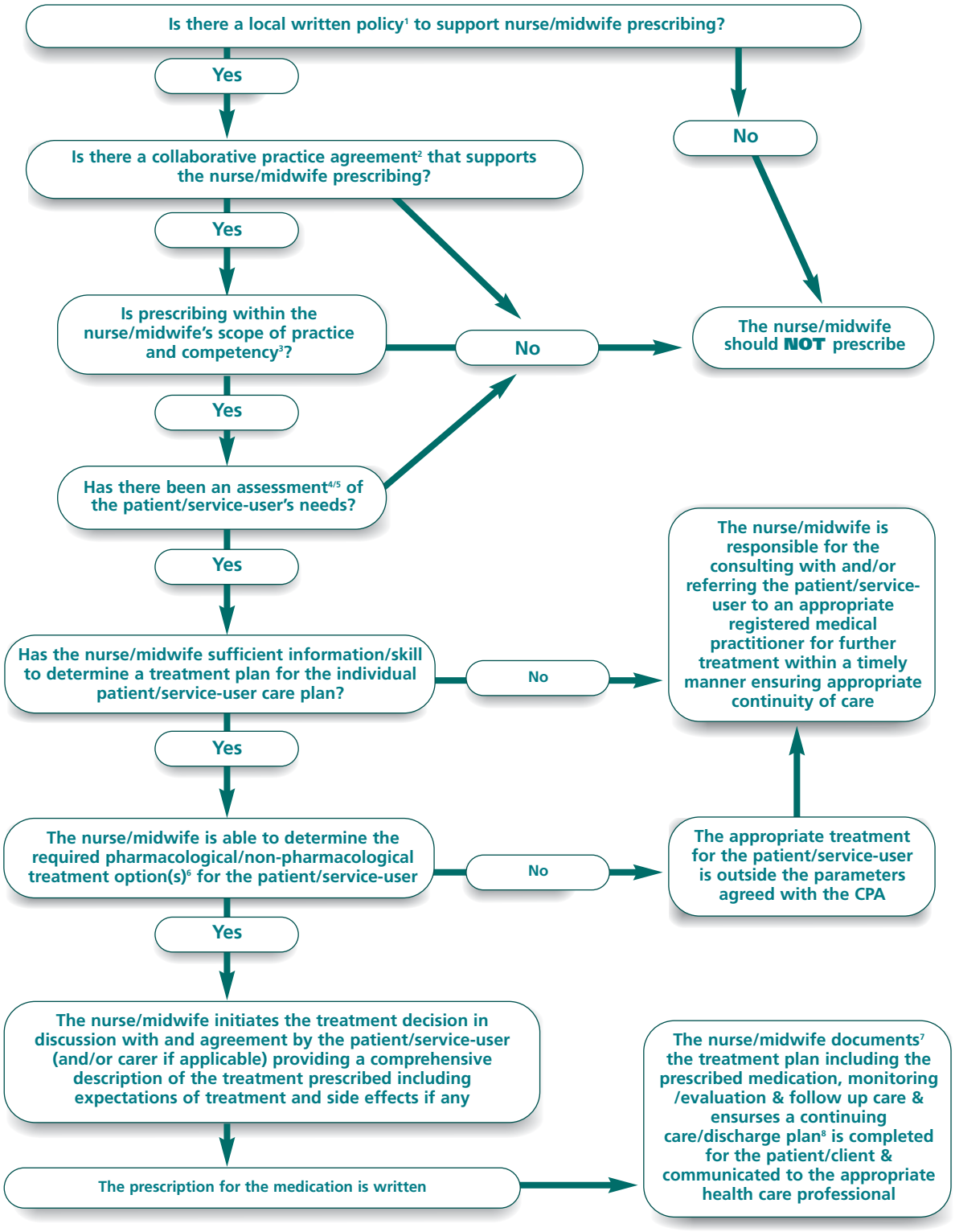
Resources

The following resources may be useful for developing prescribing practice and maintaining competence for practice:

- Irish Medicines Board
  www.imb.ie
- Summary Product Characteristics and Patient Information Leaflets Online
  www.medicines.ie
- National Medicines Information Centre
  www.nmic.ie
- Irish Medication Safety Network
  www.imsn.ie.
- World Health Organisation resources on patient safety
  www.who.int/patientsafety/solutions/en/
- National Institute for Health and Clinical Excellence
  www.nice.org.uk
- The National Library for Health and Clinical Knowledge summaries
  http://cks.library.nhs.uk
- National Prescribing Centre
  www.npci.org.uk
- NHS National Patient Safety Agency
  www.npsa.nhs.uk.
- Institute for Safe Medicine Practices
  www.ismp.org.
- National Co-ordinating Council for Medication Error Reporting and Prevention
  www.nccmerp.org.

Appendix 6

Decision-Making Framework for Nurse and Midwife Prescribing



Explanatory Notes overleaf

Explanatory Notes

1 Policy identifies the structures that authorise and provide a framework for the practice of nurse/midwife prescribing in the organisation. This may include reference to the involvement of Drugs and Therapeutics, Risk Management and Clinical Governance Committees.

2 The collaborative practice agreement (CPA) is drawn up with the agreement of the nurse/midwife, the registered medical practitioner, and the employer outlining the parameters of the nurse/midwife's prescribing authority (his/her scope of practice). Refer to the An Bord Altranais publication Collaborative Practice Agreement for Nurses and Midwives with Prescriptive Authority (2007).

3 Scope of practice and competency – Does the nurse/midwife meet the requirements and standards set by An Bord Altranais through completion of the education programme for nurse/midwife prescribing? Is he/she on the Division of the Register of Nurse Prescribers as maintained by An Bord Altranais? Is the RNP undergoing continuing professional development in prescribing practice to enable competency assessment?

4 Assessment includes:
- Physical examination
- History taking (including medications)
- Clinical diagnostic decision*
  (diagnosis, hypothesis)

5 Orders and interprets laboratory and other diagnostic tests – e.g. bloods and spirometry.

6 If the patient/service-user's assessed needs exceed the nurse/midwife's scope of practice, the patient/service-user is referred to the appropriate registered medical practitioner.

7 Documentation and record keeping for RNPs should be outlined in local policy e.g. prescription writing including prescription pad responsibilities, medication administration record and patient/service-user's individual case notes; supporting material for clinical audit of the RNP's prescribing practice.

8 Continuing care/Discharge plan – Monitoring of therapeutic effect of the prescribed treatment by the registered medical practitioner/RNP and other team members.

* An example: a nurse with prescriptive authority is working in the diabetic day care centre. Her patient population includes individuals with known diagnoses of insulin dependent diabetes. A patient presents with a pattern of hyperglycemia. The nurse through her assessment skills checks for ketones in the urine and for any source of infection. She also enquires about any recent changes in the patient's diet. Based on this information the nurse make a clinical diagnostic decision regarding the elevated blood sugars and the insulin dose is adjusted appropriately.

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