



Training non-medical prescribers in practice

*A guide to help doctors prepare for and carry out the role of
designated medical practitioner*

February 2005

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Contents

Introduction	2
The context of current developments	2
Extension of prescribing responsibilities: the story so far	2
The introduction of extended formulary nurse prescribers (EFNP)	3
The introduction of supplementary prescribing	3
Legal framework for prescribing	3
Current mechanisms for prescribing, supply and administration of medicines	3
Identifying and preparing new non-medical prescribers	4
Key principles	4
Identifying potential candidates for training	4
Prioritising potential trainees	6
Preparation programmes and outline curricula	6
The role and responsibilities of the designated medical practitioner	7
Criteria for becoming a designated medical practitioner	7
Competencies for designated medical practitioners	7
What is a designated medical practitioner expected to do?	7
Will this impact on the clinical time?	8
Working with higher education institutions	8
Teaching and learning	8
How do adults learn?	8
The learning cycle	8
Learning styles	9
Self-directed learning	10
Establishing a learning contract	10
Acquiring competencies to prescribe	10
What is 'competency'?	10
Using competencies to identifying learning needs	11
Assessment	11
Types of assessment	11
When to carry out assessment	11
Assessing competency	12
Useful websites	12
Further reading	13
References	14
Appendix 1: Independent prescribing, supplementary prescribing and patient group directions	15

Introduction

The outline curricula for preparing both extended formulary nurse prescribers (EFNPs) / nurse supplementary prescribers and pharmacist supplementary prescribers require the trainees to undergo a period of learning and assessment in practice. This practice component must be directed and assessed by a named medical practitioner (hereafter referred to as the designated medical practitioner [DMP]) who ideally works within the same area of practice as the trainee. The broad aim of this practice component is to ensure that the students are exposed to a range of learning opportunities that will meet their expected learning outcomes and help them to achieve the competencies needed to prescribe safely and effectively.

Whilst many doctors already have a training role and assessment skills, this new role of supervisor and assessor of trainee non-medical prescribers may require additional knowledge and skills.

This electronic guide aims to help health care organisations identify individuals who may be suited to the role of DMP and help doctors to prepare for and carry out the role by:

- Providing background to the extension of prescribing responsibilities in the context of the wider health care agenda
- Considering how to identify potential non-medical prescribers
- Outlining the role and responsibilities of the DMP in relation to teaching and assessing trainee prescribers
- Presenting an overview of some of the theory underpinning teaching and learning
- Hyper-linking its users to up-to-date information from a number of sources

The context of current developments

Extension of prescribing responsibilities: the story so far

Extending prescribing responsibilities to health care professionals other than doctors and dentists is already playing a key role in achieving the aims of the NHS Plan by:

- Increasing their contribution to meeting the needs of local health economies
- Enabling teams of health care professionals to deliver more flexible services and, sometimes, complete episodes of care for hard to reach and vulnerable groups

The introduction of non-medical prescribing is an integral part of the larger agenda to modernise the NHS. The government clearly views the extension of prescribing responsibilities as fundamental to this process. This has been confirmed within several Department of Health (DH) documents during recent years, including:

- **Making a difference: strengthening the nursing, midwifery and health visitor contribution to health and healthcare (January 1999)**, which re-affirmed the Government's intention to:

'... extend the role of nurses, midwives and health visitors to make better use of their knowledge and skills — including making it easier for them to prescribe'

- The report of the **Review of prescribing, supply and administration of medicines (March 1999)**, which recommended that:
 - Prescribing responsibilities be extended to include professional groups other than doctors, dentists, district nurses and health visitors
 - Following diagnosis, responsibility for the clinical management of some patients, including prescribing, could be passed to another health professional — now referred to as the supplementary prescriber

- **The NHS plan: a plan for investment, a plan for reform (July 2000)**, which emphasized:
 - That services should be organised and delivered around the needs of patients
 - The importance of breaking down traditional demarcations between clinical roles
 - The need for clinical professionals to work more flexibly for the benefit of patients
- **Pharmacy in the future — implementing the NHS plan (September 2000)**, which set out:
 - The vital role of pharmacy in delivering the NHS Plan
 - The vision for pharmacy
 - An outline programme for the development of pharmacy services in the UK
- **The PCT Competency Framework (July 2004)**, produced by the National Primary and Care Trust (NatPaCT), which highlighted the contribution supplementary prescribers have in meeting the NHS Plan targets and the need to utilise non-medical professionals in managing minor illness, minor injuries and maximising self-care

The introduction of extended formulary nurse prescribers

In May 2001, the Government announced that ‘independent’ prescribing responsibilities would be extended to enable more groups of nurses to prescribe a wider range of medicines from the Nurse Prescribers’ Extended Formulary (NPEF) to treat a defined list of conditions. Training of EFNPs began in early 2002.

Ten new medical conditions and 30 new Prescription Only Medicines (POMs) were added to the NPEF from February 2004, which now consists of 180 POMs.

Subject to Parliamentary approval, changes to expand the range of medical conditions and medicines in the NPEF, particularly for emergency care, are anticipated by Spring 2005.

The DH is also considering the development of a framework for independent prescribing by pharmacists.

The introduction of supplementary prescribing

The decision to grant nurses and pharmacists supplementary prescribing responsibilities was announced in November 2002. This meant that pharmacists would be able to prescribe for the first time and nurses would be able to prescribe for long-term conditions.

In Summer 2004, the Medicines and Healthcare products Regulatory Agency (MHRA) and DH conducted a formal consultation on proposals for supplementary prescribing by chiropodists / podiatrists, physiotherapists, radiographers and optometrists. Subject to Parliamentary approval changes to regulations to enable this are expected in Spring 2005.

Legal framework for prescribing

The law which governs prescribing in general is found in the:

- Medicines Act 1968 (Primary legislation)
- Medicinal Products: Prescription by nurses etc. Act 1992
- Medicinal (Products other than veterinary drugs) (Prescription Only) Order 1983 SI 1212
- Prescription Only Medicines (Human Use) Order
- Health and Social Care Act 2001

Current mechanisms for prescribing, supply and administration of medicines

There are now several **legal mechanisms for prescribing, supplying and administering medicines to patients.** These are:

Independent prescribing, whereby the prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing, and the appropriateness of any prescribing. Currently doctors, dentists and some nurses are independent prescribers. See Appendix 1 for more information

Supplementary prescribing, which is defined by the DH as:

'... a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient-specific Clinical Management Plan with the patient's agreement.'

See Appendix 1 for more information

Patient specific directions, which are written instructions from a doctor, dentist or nurse prescriber for a medicine to be supplied and / or administered to a named person. This could be demonstrated by a simple request in the patient's notes or an entry on the patient's drug chart

Medicines Act exemptions, which allow certain groups of health care professionals to sell, supply and administer particular medicines directly to patients

Patient group directions (PGDs), are written instructions which allow some health care professionals to supply and administer a range of medicines to patients without the need for a prescription or an instruction from a prescriber in certain circumstances. See Appendix 1 for more information

Identifying and preparing new non-medical prescribers

Key principles

The key principles of the extension of prescribing responsibilities are:

- Patient safety is paramount
- Patients should benefit by enabling faster access to care, including the medicines they need. They should also benefit from having their care actively managed by 'experts' in their condition (for example, specialist nurses and / or pharmacists). This should result in patients receiving more detailed advice on their treatment and a high level of concordance
- The organisation / service should benefit by making better use of available resources. Maximising the potential of existing skills of a range of health care professionals will increase their contribution to the work of the whole health care team. This means that doctors should have more time to concentrate on those patients who need the level of care that only a doctor can provide

Identifying potential candidates for training

When identifying potential candidates for training, NHS and GP employers need to ensure that:

- Nominees meet the eligibility criteria for entry onto the preparation programme, outlined on page 5
- The individuals are willing and able to undertake the course. No-one should be nominated to train as a prescriber if they do not wish to prescribe or will not have the opportunity to prescribe once qualified
- Their subsequent prescribing practice will provide maximum benefit to patients
- Best value is gained from training resources. This means that new prescribers should have the opportunity to prescribe often enough to maintain competence and confidence in prescribing, thus protecting patient safety and maximising the number of patients who may benefit from their prescribing expertise

Eligibility criteria for training as a EFNP / nurse supplementary prescriber

Nurses must:

- Be a 1st level registered nurse or registered midwife
- Have valid registration on the Nursing and Midwifery Council's (NMC) professional register
- Be capable of study at Level 3 (1st degree level)
- Have at least three years post-registration clinical nursing experience (or part-time equivalent); most nominees are likely to be at E Grade or above, or Agenda for Change equivalent
- Have a medical prescriber willing to contribute to the 12 days learning in practice element of preparation, and a period of supervised prescribing post-qualification. The medical prescriber will also be required to participate in the assessment process
- Have the agreement of his / her employing organisation to allow attendance and completion of all elements of the prescribing course, the necessary period of supervised prescribing following qualification as a prescriber, and continuing professional development
- Have commitment from their employer to enable access to a prescribing budget and make other necessary arrangements for prescribing practice, upon successful completion of the course
- Occupy a post in the employment of an NHS organisation or GP practice in which they will need to prescribe

Eligibility criteria for training as a pharmacist supplementary prescriber

Pharmacists must:

- Be currently registered with the Royal Pharmaceutical Society of Great Britain (RPSGB) and / or Pharmaceutical Society for Northern Ireland
- Have at least two years experience as a pharmacist following their pre-registration year after their graduation
- Have support from the sponsoring organisation, e.g. a primary care organisation or NHS Trust, including confirmation that the entrant will have appropriate supervised practice in the clinical area in which they are expected to prescribe and that there is an identified service need for this extension of role
- Have a named medical practitioner, recognised by the employing / health service commissioning organisation
 - a) As having experience in a relevant field of practice
 - b) Training and experience in the supervision, support and assessment of trainees
 - c) Who has agreed to:
 - Provide the student with opportunities to develop competencies in prescribing
 - Supervise, support and assess the student during their clinical placement
- They will have access to continuing professional development opportunities on completion of the course
- For pharmacists working in primary care they should have access to a budget to meet the costs of their prescriptions on completion of the course

Prioritising potential trainees

It is likely that many nurses, pharmacists and allied health professionals will meet the eligibility criteria for places on the training courses. However, priority to access NHS centrally-funded places should be given to clinicians who:

- Run their own clinics or services
- Normally work in isolation from other prescribers
- Could complete episodes of care by being able to prescribe
- Are likely to be able to prescribe for more than one medical condition. For EFNPs this refers to the conditions set out in the Drug Tariff, the British National Formulary (BNF) and listed on the **DH website**
- Hold additional qualifications whereby their professional expertise would facilitate prescribing for specified medical conditions

Preparation programmes and outline curricula

Preparation for pharmacists

At least 25 taught days of which a substantial proportion will be face-to-face contact, although other ways of learning are also considered

At least, an additional 12 days learning in practice

An element of self-directed study

The **supplementary prescribing section** of the RPSGB's website includes the **outline curriculum for training programmes** and details of Higher Education Institutions (HEIs) offering supplementary prescribing programmes available.

Preparation for nurses

At least 26 taught days of which a substantial proportion will be face-to-face contact, although other ways of learning are also considered

An additional 12 days learning in practice

An element of self-directed study

The NMC have determined a **standard** in respect of EFNP and nurse supplementary prescribing.

This means that nurses who successfully complete this course are qualified and legally able to prescribe from the NPEF **and** as supplementary prescribers. However, in some situations these nurses may only be able to make use of one of these modes of prescribing. For example, it is unlikely that supplementary prescribing will be appropriate for nurses working in first contact services.

In essence, the outline curriculum for this course consists of the **outline curriculum developed by the English National Board for Nurses, Midwives and Health Visitors to prepare EFNPs** plus the **DH framework** for the preparation of nurse supplementary prescribers.

The preparation programmes are run by those HEIs which have been approved by the appropriate professional body / bodies to do so. Each of these HEIs will have met the requirements set out in the outline curricula. However, the actual content, mode of delivery and assessment strategies of individual courses may differ.

The role and responsibilities of the designated medical practitioner

The curricula for preparing nurse and pharmacist prescribers include no less than 12 days of learning in practice. The curricula to prepare allied health professionals (initially chiropodists / podiatrists, radiographers and physiotherapists) and optometrists as supplementary prescribers will include similar requirements.

This period of learning in practice is to be directed by a DMP who will also be responsible for assessing whether the learning outcomes have been met and whether the trainee has acquired certain competencies. Normally, these outcomes and competencies will be identified by the HEI running individual courses.

Criteria for becoming a designated medical practitioner

Eligibility criteria for becoming a DMP

The DMP must be a registered medical practitioner who:

- Has normally had at least three years recent clinical experience for a group of patients / clients in the relevant field of practice
- Is within a GP practice and is either vocationally trained or is in possession of a certificate of equivalent experience from the Joint Committee for Post-graduate Training in General Practice Certificate **or** is a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer
- Has the support of the employing organisation or GP practice to act as the DMP who will provide supervision, support and opportunities to develop competence in prescribing practice
- Has some experience or training in teaching and / or supervising in practice
- Normally works with the trainee prescriber. If this is not possible (such as in nurse-led services or community pharmacy), arrangements can be agreed for another doctor to take on the role of the DMP, provided the above criteria are met and the learning in practice relates to the clinical area in which the trainee prescriber will ultimately be carrying out their prescribing role

Competencies for designated medical practitioners

Before taking on the role of DMP the doctor, and the organisation, should consider the competencies needed to effectively undertake this role.

The West Midlands Deanery has identified the following broad, core competency areas for GP trainers which can be adapted and used as a checklist for potential DMPs.

The ability to create an environment for learning

Personal characteristics

Teaching knowledge

Teaching skills

The components which make up the core competencies are available from the [GP Trainer website](#).

What is a designated medical practitioner expected to do?

The DMP has a crucial role in educating and assessing non-medical prescribers. This involves:

- Establishing a learning contract with the trainee
- Planning a learning programme which will provide the opportunity for the trainee to meet their learning objectives and gain competency in prescribing
- Facilitating learning by encouraging critical thinking and reflection
- Providing dedicated time and opportunities for the trainee to observe how the DMP conducts a consultation / interview with patients and / or carers and the development of a management plan
- Allowing opportunities for the trainee to carry out consultations and suggest clinical management and prescribing options, which are then discussed with the DMP
- Helping ensure that the trainees integrate theory with practice
- Taking opportunities to allow in-depth discussion and analysis of clinical management using a random case analysis approach, when patient care and prescribing behaviour can be examined further
- Assessing and verifying that, by the end of the course, the trainee is competent to assume the prescribing role

Will this impact on the clinical time?

Training new prescribers will undoubtedly take up some time. As the approach to teaching and learning should be developed on an individual basis, it is difficult to predict how much time this will involve but it is likely that consultation time will be reduced. It is unlikely that the trainee will need to spend all of the period of learning in practice with the DMP, as other clinicians may be better placed to provide some of the learning opportunities. However, the DMP remains responsible for assessing whether the learning outcomes have been met.

Working with higher education institutions

It is essential that the DMP and HEIs running the prescribing programme work closely together. Most HEIs offer DMPs a range of support to facilitate this, which may include:

- An orientation session and / or information before the start of each programme
- A handbook / briefing notes, including information on the course content, learning outcomes, timetable and assessment strategy
- An assessment workbook / log
- Practice visits
- Assessment of the learning environment
- On-going contact

Teaching and learning

How do adults learn?

The mechanisms of adult learning are both complex and relatively unknown. **Zemke and Zemke present 30 points** which emerge from a range of knowledge about adult learning.

It is generally acknowledged that adults learn in a different way to children and adolescents. According to Brookfield (cited on the **GP Trainer website**), adult learners display the following characteristics:

- They are not beginners, but are in a continuing process of growth
- They bring a unique package of experiences and values with them
- They come to education with intentions
- They bring expectations about the learning process
- They have competing interests — the realities of their lives
- They already have their own set patterns of learning

So, adults learn best when:

- They are engaged in planning their learning programme
- They are encouraged to be self-directed
- Their past experiences are taken into account and used within the learning process
- They can recognise how the learning can be applied in a practical way
- Their individual learning needs and learning styles are taken into account
- The trainer / educator takes a facilitative approach to teaching, rather than a didactic one
- The climate / environment is conducive to learning

The learning cycle

Lewin's cycle of adult learning is based on **experiential learning** and consists of four stages, which follow on from each other. These are:

Lewin's cycle of adult learning

Concrete experience

Observation and reflection (on that experience on a personal basis)

Forming abstract concepts, whereby the learner can describe the experience or apply the theories which apply to it

Active experimentation or testing in new situations, whereby the learner constructs ways of modifying the next occurrence of a particular experience

Once complete, this process, in turn, leads to the next 'concrete experience'

There is a wealth of information on a range of theories about experiential learning. One source can be accessed from the [Encyclopaedia of Informal Education website](#).

Another approach, which is sometimes used in Higher Education, is the '**conscious competence**' learning model, sometimes referred to as a 'ladder' or 'matrix'. This model can also be used as a tool for assessment. Although its origins seem to be unclear, this model suggests that learning takes place in four stages.

The conscious competence learning model

Stage 1: Unconscious incompetence — the trainee doesn't know what they don't know and their confidence exceeds their ability

Stage 2: Conscious incompetence — the trainee knows what they don't know. Confidence drops with the realisation of what needs to be learned

Stage 3: Conscious competence — the trainee acquires a new skill / knowledge, but has to consciously think about it

Stage 4: Unconscious competence - the new skills / knowledge blend together and become habits. Confidence and ability has peaked and the trainee no longer has to think about it

This is the start of a new learning curve

The trainee always starts at stage 1 and finishes at stage 4, passing through the other stages on the way. When learning advanced skills, trainees may regress to previous stages if they haven't had the opportunity to practice these skills.

More information about the '**conscious competence**' model is available from the [GP Trainers Course website](#) and [businessballs.com](#).

Learning styles

Different people learn in different ways and an individual's learning style may consist of a number of different preferences.

People are often unaware of their preferred learning style. However, knowing this, and understanding it, is key to becoming effective at learning from experience.

One of the most popular approaches to identifying individual learning styles was developed by Honey and Mumford. Their learning styles questionnaire identifies four learning styles.

Honey and Mumford learning styles

Activists involve themselves fully and learn best from new experiences, generating ideas and trying things out. They prefer to work in intuitive and spontaneous ways. Problem-solving, group work and discussion work better for them than more passive approaches to learning

Reflectors like to stand back and ponder on experiences and consider them from a range of perspectives. They learn best from activities which allow them time to make a considered judgement in their own time

Theorists adapt and integrate observations into logical theories. They go through things logically and are less comfortable with subjective opinion and creative thinking

Pragmatists are keen to try out ideas to see if they work in practice. They learn best from activities that have a clear practical value and prefer testing ideas and approaches

More information about the Honey and Mumford learning styles is available at [Peter Honey Publications](#).

Self-directed learning

There is a school of thought that adults learn best from self-directed learning.

Teaching of adults should be aimed at guiding the trainees learning rather than direct instruction. In reality, effective teaching and learning often requires a blend of both approaches, based on what is being taught.

More information on self-directed learning is available from the **National Teaching and Learning Forum** and the **self-directed learning web page**.

Establishing a learning contract

The use of learning contracts has become very popular in adult learning.

There is a wealth of detailed information on learning contracts and how to develop them, some of which is available electronically from the **Scottish Council for Postgraduate Medical and Dental Education website** and the **UK Training News website**.

Learning contracts

Are agreements between a teacher and a learner

Provide a tool for making learning objectives explicit, guiding learning and monitoring whether planned learning is meeting the course learning

Are based on an active partnership between the teacher and learner whereby both partners participate in the learning process, thus developing a sense of ownership and commitment

Can be presented in a range of formats but are usually written or electronically generated documents

Typically address and specify (Knowles 1986):

- The trainees' learning needs
- The learning objectives (the knowledge, skills, attitudes and values the learner needs to acquire)
- What needs to happen in order to meet these objectives, including learning resources and strategies
- Target dates for meeting the stated objectives
- What evidence will be required to demonstrate that the learning objectives have been met
- How that evidence will be judged

Acquiring competencies to prescribe

The National Prescribing Centre (NPC) has identified the competencies needed by a range of prescribers to prescribe safely and effectively. These are presented in the following documents as outline frameworks, available from the **NPC website**.

- **Maintaining competency in prescribing: an outline framework to help nurse prescribers.** First edition. November 2001
- **Maintaining competency in prescribing: an outline framework to help nurse supplementary prescribers.** Update. March 2003
- **Maintaining competency in prescribing: an outline framework to help pharmacist supplementary prescribers.** First edition. March 2003
- **Competency framework for prescribing optometrists.** First edition. May 2004
- **Maintaining competency in prescribing: an outline framework to help allied health professional supplementary prescribers.** First edition. July 2004

What is 'competency'?

Although competency is described in different ways by different organisations two main 'themes' repeatedly occur in the range of definitions. These are:

- **Task-based competencies**, which are essentially descriptions of work tasks or job outputs and have their origins in national training schemes, such as National Vocational Qualifications (NVQs)
- **Behavioural competencies**, which are thought of as underlying characteristics which result in effective performance. They are described as a combination of knowledge, skills, motives and traits. Competency in this sense is generally best seen in the way someone behaves as they help individuals, their educators and their managers to recognise what is needed to carry out a particular job / role safely and effectively

The NPC frameworks of prescribing competencies were developed using a behavioural competency approach.

So, competency in this case could be described as having the right skills, knowledge and attitudes to properly, and consistently carry out the prescribing role.

Using competencies to identifying learning needs

A learning need could be described as the gap between where the trainee is starting from and where they need to be in terms of acquiring particular competencies — in this case, the competencies needed to prescribe safely and effectively.

HEIs will have identified the competencies which the trainee prescriber must acquire in order to meet the requirements of the course, often based on the NPC competency frameworks.

It is important to remember that some trainee prescribers, because of their clinical role, experience, existing knowledge base and level of skill, may already have degrees of competency in some areas.

For this reason it is important that DMPs and trainees are both actively involved in assessing the initial level of competency and then identifying the individual's learning needs.

Assessment

Types of assessment

Two types of assessment are most commonly used:

Types of assessment

Summative assessment, which refers to whether the trainee has met all the objectives and learning outcomes. It is usually quite formal and relates to whether the trainee has 'passed' or 'failed'

Formative assessment, which is a continuous process. It aims to provide on-going feedback to both the DMP and the trainee to help evaluate the effectiveness of the learning programme, monitor the level of achievement, identify outstanding learning needs and focus future action

Credible assessment should have the following five attributes:

- **Reliability** — what is the variation in results due to the differences in trainees performance and different assessors rating of the same performance?
- **Validity** — does the assessment really measure what it is intended to measure?
- **Acceptability** — is the method of assessment acceptable to all stakeholders?
- **Feasibility** — can the assessment be delivered to all those who require it within available resources?
- **Educational impact** — will the assessment, through appropriate feedback, help the trainee improve?

In reality, assessment processes are a compromise between these five attributes, with the emphasis on each attribute being dependent on the purpose of the assessment.

More detailed insights into assessing clinical competency have been presented by **Piercey (1995)** and Wass V et al (2001).

When to carry out assessment

Assessment of competency during the clinical placement should be on-going and formative assessment should be a regular feature of this process.

Summative assessment of individual competencies can be carried out in any order and at any time, as identified within the learning contract.

It is important to remember that assessment of a competency cannot take place until the trainee has had enough time and opportunity to develop that competency.

Assessing competency

Appropriate training clearly plays a big part in acquiring competency. However, this cannot be assumed; the DMP must be satisfied that the trainee can perform consistently and in line with the identified standards and competencies.

It is, therefore, essential that assessment of competency (both initially and throughout the programme) is based on evidence presented by the trainee.

McKinley et al (2001) present a case for obtaining direct evidence of clinical competence and describe how this evidence may be gathered. Although the article focuses on revalidation of clinicians, it would seem the principles could also be applied to trainees.

Miller's pyramid conceptualises the elements of clinical competence as follows, starting at the base of the pyramid:

- **Knows** — the trainee knows the basic facts
- **Knows how** — the trainee can use the knowledge, for example clinical reasoning or problem solving
- **Shows how** — this reflects hands-on behaviour in a simulated practice situation
- **Does** — refers to actual performance in the real situation

The trainees should be assessed gradually over the placement period, starting with the lowest level of the pyramid and aiming for the higher levels of **Shows how** or **Does**. It is important to remember that trainees may only be expected to display 'Shows how' for some of the competencies.

Useful websites

Department of Health website contains up-to-date information on all aspects of DH work, including prescribing.

DrugInfoZone is a medicines information knowledge base primarily for health care professionals working in the UK NHS.

Encyclopaedia of Informal Education is an independent website which explores the theory and practice of informal education and lifelong learning.

GP Trainers Course website, home to the West Midlands' Modular Trainers Course, provides access to a range of teaching resources, including competencies for trainers.

International Journal of Pharmacy Practice, established by the RPSGB primarily for the publication of peer-reviewed papers describing research into all aspects of the practice of pharmacy and related matters.

Medicines Partnership. This initiative, supported by the DH, aims at enabling patients to get the most from their medicines.

NatPaCT

National Pharmaceutical Association is the national body of Britain's community pharmacy owners.

National Prescribing Centre is a health service organisation, formed in April 1996 by the DH. Its aim is to 'promote and support high quality, cost-effective prescribing and medicines management across the NHS, to help improve patient care and service delivery'.

NHS Confederation

Nurse Prescriber

Nursing and Midwifery Council

Patient group directions is a centrally maintained archive of approved PGDs.

Peter Honey Publications produce on-line questionnaires (including the learning styles questionnaire), booklets for learners and manuals for trainers.

Pharmaceutical Journal

Pharmaceutical Press, the publications division of the RPSGB, produces books, journals and related electronic products on pharmacy, the pharmaceutical sciences and other related disciplines.

PRODIGY is a source of clinical knowledge, based on the best available evidence, about the common conditions and symptoms managed by primary health care professionals.

Royal College of Nursing

Royal College of Physicians

Royal Pharmaceutical Society of Great Britain

Ruby3 has a section on learning theory as well as providing links to training websites.

Scottish Council for Postgraduate Medical and Dental Education

Self-directed learning web page is primarily targeted at those interested and / or involved in self-directed learning, much of the information on this website is based on the International Self-directed Learning Symposium and includes techniques, tools and resources for the self-directed learner.

Teaching and learning forum provides useful information and links on a range of teaching and learning issues.

UK Medicines Information

UK Training News

Further reading

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Appendix 1: Independent prescribing, supplementary prescribing and patient group directions

Independent prescribing

The prescriber takes responsibility for:

- The clinical assessment of the patient
- Establishing a diagnosis
- The clinical management required, as well as responsibility for prescribing where necessary, and the appropriateness of any prescribing

Doctors, dentists and some nurses are currently independent prescribers.

There are two mechanisms for nurses to prescribe independently:

- As district nurses and / or health visitors, qualified to prescribe from the limited Nurse Prescribers' Formulary for District Nurses and Health Visitors (NPF)
- As extended formulary nurses prescribers (EFNPs) able to prescribe from the Nurse Prescribers' Extended Formulary (NPEF)

EFNPs can currently prescribe the following medicines to treat a defined list of conditions as listed on the **DH website**:

- All General Sales List and Pharmacy medicines currently prescribable by GPs at NHS expense
- Around 180 POMs, including the following six controlled drugs:
 - Codeine Phosphate, Co-Phenetrope and Dihydrocodeine Tartrate, plus Diazepam, Lorazepam and Midazolam for use in palliative care only

Subject to Parliamentary approval, changes to expand the range of medical conditions and medicines in the NPEF, particularly for emergency care are anticipated by Spring 2005.

Supplementary prescribing

Supplementary prescribing is defined by the DH as:

'... a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan with the patient's agreement.'

At present, only nurses and pharmacists may train to become supplementary prescribers. However, proposals are well advanced for supplementary prescribing by chiropodists / podiatrists, physiotherapists, radiographers and optometrists. Subject to Parliamentary approval, changes to regulations to enable this are expected in Spring 2005.

The **key principles** underpinning supplementary prescribing emphasize:

- The importance of communication between the prescribing partners
- The need for access to shared patient records
- That the patient is treated as a partner in their care and is involved at all stages in decision making, including whether part of their care is delivered via supplementary prescribing

The **criteria** that are currently set in regulations for **lawful supplementary prescribing** are:

- The independent prescriber must be a doctor (or dentist)
- The supplementary prescriber must be a Registered Nurse, Registered Midwife or a Registered Pharmacist
- There must be a written Clinical Management Plan (CMP) relating to a named patient and to that patient's specific conditions. Agreement to the plan must be recorded by both the independent and supplementary prescriber before supplementary prescribing begins
- The independent and supplementary prescriber must share access to, consult and use the same common patient record

The **aim** of supplementary prescribing is to provide patients with quicker and more efficient access to medicines by fully utilising the skills of health care professionals other than doctors whilst, at the same time, safeguarding patient safety.

In broad terms, supplementary prescribing hinges on:

- The formulation of a voluntary partnership between an independent prescriber (doctor or dentist) and a supplementary prescriber (currently a nurse or pharmacist)
- Following diagnosis and with the patients' agreement, an individual evidence-based CMP will be drawn up and agreed by all parties
- From this point the future management of the identified condition(s) (including prescribing), within the parameters of the CMP, will be delegated to the supplementary prescriber

The **CMP**:

- Is the foundation of supplementary prescribing and must be in place before supplementary prescribing can begin
- Is a written or electronic document and should be included in the patient's record
- Relates to a named patient and specifies the condition(s) to be managed by a supplementary prescriber

Regulations specify that the **CMP must include** the following:

- The name of the patient to whom the plan relates
- The illness or conditions which may be treated by the supplementary prescriber
- The date on which the plan is to take effect, and when it is to be reviewed by the doctor or dentist who is party to the plan
- Reference to the class or description of medicines or types of appliances which may be prescribed or administered under the plan
- Any restrictions or limitations as to the strength or dose of any medicine which may be prescribed or administered under the plan, and any period of administration or use of any medicine or appliance which may be prescribed or administered under the plan. The CMP may include a reference to published national or local guidelines. However these must clearly identify the range of the relevant medicinal products to be used in the treatment of the patient, and the CMP should draw attention to the relevant part of the guideline. Any guideline referred to also needs to be easily accessible
- Relevant warnings about known sensitivities of the patient to, or known difficulties of the patient with, particular medicines or appliances

- The arrangements for notification of:
 - Suspected or known reactions to any medicine which may be prescribed or administered under the plan, and suspected or known adverse reactions to any other medicine taken at the same time as any medicine prescribed or administered under the plan
 - Incidents occurring with the appliance which might lead, might have led or has led to the death or serious deterioration of state of health of the patient
- The circumstances in which the supplementary prescriber should refer to, or seek the advice of, the doctor or dentist who is party to the plan

Two suggested templates for CMPs, which may be individualised to meet the patient's needs, are available to download from the **DH website**.

Several examples of draft CMPs are available some of which can be found on the **Nurse Prescriber** and **DrugInfoZone** websites.

There are no legal restrictions on the clinical conditions which supplementary prescribers may treat. As supplementary prescribing requires a prescribing partnership and a CMP before it can begin, it is likely to be most useful in dealing with long-term medical conditions. However, it is for the independent prescriber with the supplementary prescriber to decide when supplementary prescribing is appropriate, taking into account the clinical knowledge, skill and competency of the supplementary prescriber.

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

- All General Sales List medicines, Pharmacy medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances
- All POMs with the current exception of controlled drugs. Changes to the Home Office's Misuse of Drugs Regulations and to related amendments to NHS Regulations are needed to enable prescribing of controlled drugs under supplementary prescribing. This is being

considered in the wider context of the Shipman Inquiry report. Subject to Parliamentary approval, changes to misuse of drugs regulations will take place from 14th March 2005. NHS regulations amendments will follow as soon as possible

- Medicines for use outside of their licensed indications (i.e. 'off label' prescribing), 'black triangle' drugs, and drugs marked 'less suitable for prescribing' in the BNF
- Unlicensed drugs that are part of a clinical trial which has a clinical trial certificate or exemption

It should be noted that the supplementary prescriber should not be required to enter into a prescribing partnership that entails them prescribing any medicine that they do not feel competent to prescribe.

Other information on supplementary prescribing includes:

- **Supplementary prescribing by nurses and pharmacists with the NHS in England a guide for implementation**, available from the DH website
- Up-to-date information on supplementary prescribing, including 'frequently asked questions', can also be found on the **DH website**
- The NPC's web-based publication **Supplementary Prescribing: a resource to help healthcare professionals to understand the framework and opportunities (2003)** which presents a concise overview of some of the elements of supplementary prescribing and helps users access definitive information from a number of sources

Supply and administration under patient group directions

HSC 2000/026: Patient group directions [England only]

PGDs can be used by a number of health professionals to supply and / or administer a wide range of medicines, in many areas of clinical practice — it is not a form of prescribing.

A PGD is legally defined as:

'... a written instruction for the sale, supply and / or administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presentation for treatment. It is not a form of prescribing and there is no specific training that health professionals must undertake before supplying medicines in this way.'

Guidance accompanying the definition sets out the context in which PGDs should be used as follows:

'The majority of clinical care should be provided on an individual, patient-specific basis. The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for the patient without compromising patient safety and where it is consistent with appropriate professional relationships and accountability.'

Whilst they provide a useful mechanism of ensuring that in certain circumstances, patients receive the medicines they need in a timely manner, they do have limitations. PGDs seem to be most useful in services where medicines use can be predicted as they are most appropriate in managing specific episodes of treatment, such as in first contact services. However, the preferred route for patients to receive their medicines remains prescribing to an individual patient by an appropriately trained professional, on a one-to-one basis.

The NPC's on-line resource **Patient group directions: a practical guide and framework of competencies for all professionals using patient group directions** published in March 2004, offers guidance on the appropriate use of PGDs.