Guidelines for prescribing in medical aesthetics.

Nurse Independent Prescribers prescribing for patients outside of their immediate care.

15 August 2012
Introduction

The requirement for these guidelines evolved from the positions of the NMC and GMC with regard to remote prescribing in medical aesthetics. It will be understood by all with an interest in this document that remote prescribing forms no part of these guidelines or indeed modern medical aesthetics. Whilst it is designed largely to address the needs in prescribing botulinum toxins, it should apply equally to all drugs and devices e.g. dermal fillers.

It is expected that the prescriber buddying relationship described in this document will be of most benefit to those non-prescribing nurses wishing to undertake the independent prescribing qualification, rather than becoming a long term business model. However it would also be a suitable model for nurses working together under the same business structure.

These guidelines are a working document. They address the current needs and concerns of BACN members but are subject to change and on-going development where varying issues are identified. It is expected that this document will therefore evolve over time.

In formulating this document, effort has been made to avoid undue rigidity. As nurses working under NMC guidelines we are afforded some luxury in using our professional judgement, provided that judgement can be justified and evidenced. It is hoped therefore that this document will be read in the light of the principles which underpin it:

- The patient is at the core of any decision to prescribe and patients’ needs are considered without reference to financial gain.
- A decision to prescribe being based on this document is made with confidence that the best interests of both prescriber and non-prescribing nurse are also protected.
- By following best practice, the interests of nursing as a group within medical aesthetics are both protected and promoted.

It is anticipated that in view of the above, the prescriber and non-prescriber would find it advantageous to form a partnership. This partnership working in agreement with the patient would form a tripartite arrangement which would be considered best practice.
Aims

To enable best practice when prescribing for patients in medical aesthetics, where the patient is under the care of a non-prescribing nurse.

To achieve a unified approach to such prescribing and create a common source of reference to accomplish this.

To facilitate on-going care of the patient, whilst the non-prescribing nurse undertakes independent prescribing qualifications, or identifies a business model that can more conveniently incorporate these guidelines.

Objective

To define, promote and clarify best practice and to encourage partnerships with manufacturers, pharmacies, insurers and all those with an interest in the industry, to help achieve these ends.

Scope

These guidelines are intended solely for the use of NMC registered prescribers who have undertaken the Nurse Independent Prescribing (NIP) qualification. It is designed for those wishing to prescribe independently, therefore the use of supplementary prescribing falls outside the scope of this document. Equally, NMC guidelines are clear that Patient Group Directions are not a form of prescribing and thus are also not relevant. Further, the issue of prescribing from stock requires a relationship with a doctor and this scenario falls outside the guidelines remit.

It is however anticipated that non prescribing nurses wishing to use the services of their prescribing colleagues will also be familiar with both this document and the NMC standards to which it relates.

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Standards of proficiency for nurse and midwife prescribers

These guidelines are not designed to be used in isolation but are supplementary to the NMC standards of proficiency for nurse and midwife prescribers and the NMC standards for medicines management. Reference is made to specific requirements outlined in the NMC standards, where appropriate, bringing these fundamental guidelines together in a unified document, to more readily serve the interests of best practice.

In addition your attention is drawn to the following overview:

Under the new legislation prescribers must have sufficient knowledge and competence to:

• Assess a patient/client’s clinical condition
• Undertake a thorough history, including medical history and medication history, and diagnose where necessary, including over-the-counter medicines and complementary therapies
• Decide on management of presenting condition and whether or not to prescribe
• Identify appropriate products if medication is required
• Advise the patient/client on effects and risks
• Prescribe if the patient/client agrees
• Monitor response to medication and lifestyle advice.

BACN best practice

It follows from the above standard that:

• Any prescriber wishing to prescribe for a non-prescribing nurse, and any nurse wishing to receive such services, must ensure that the prescriber is sufficiently experienced in all these aspects of prescribing and assessment in relation to medical aesthetics.
Standards

Repeat Prescribing

NMC prescribing standard 19

19.1 You may issue a repeat prescription, but you do so in the knowledge that you are responsible as the signatory of the prescription and are accountable for your practice.

19.2 Before signing a repeat prescription you must be satisfied that it is safe and appropriate to do so and that secure procedures are in place to ensure that:

a) The patient/client is issued with the correct prescription

b) Each prescription is regularly reviewed and is only re-issued to meet clinical need

c) A review must take place following a maximum of six prescriptions or six months elapsing

d) The correct dose is prescribed

e) Suitable provision for monitoring each patient/client’s condition is in place and for ensuring that patient/clients who need a further examination or assessment do not receive repeat prescriptions without being seen by an appropriate prescriber

BACN Best Practice.

- A repeat prescription may be issued within a maximum of six months from the date of the initial consultation.
- The client will be reviewed within this six months therefore, unless in extraordinary circumstances, there will normally only be one repeat prescription between reviews.
- The prescribing nurse will be available to monitor and review the patient after treatment.
- There must be no change to the medical history. This can be confirmed with the patient via telephone.
- There must be no change to the original prescription and patient-specific direction.
- A PSD must be included with the prescription

Method of prescribing.

NMC Medicines management. Standard 1

1 Registrants must only supply and administer medicinal products in accordance with one or more of the following processes:
1.1 Patient-specific direction (PSD)

1.2 Patient medicines administration chart (may be called a medicines administration record (MAR))

1.3 Patient group direction (PGD)

1.4 Medicines Act Exemption (where they apply to nurses)

1.5 Standing order

1.6 Homely remedy protocol

1.7 Prescription forms

2 Once a medicinal product has been prescribed and dispensed to an individual, the drug is the individual’s own property. To use it for someone else is theft. Registrants should refer to DH (2006) Medicines Matters: A guide to mechanisms for the prescribing, supply and administration of medicines.

Patient-specific direction (PSD)

3 A patient-specific direction (PSD) is a written instruction from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient. In primary care, this might be a simple instruction in the patient’s notes. Examples in secondary care include instructions on a patient’s medicines administration chart. The direction would need to be specific as to the route of administration it cannot simply authorise a course of treatment to several patients.

**BACN Best Practice**

- It is anticipated that a patient-specific direction is the appropriate method of prescribing for patients in private aesthetic practice.
- The PSD shall be recorded in the patient notes in line with section 3 above.
- It may include a specific dose e.g. glabellar 20 units, or a reasonable dose range e.g. glabellar. 20 to 25 units.
- It may include the facility for additional (top-up) treatment after two weeks.
- Where the PSD permits treatment at two week review, botulinum toxins should be reconstituted with bacteriostatic normal saline. The saline should be included with the prescription and PSD and the implications of its unlicensed status considered. There is a significant and persuasive body of evidence to justify this practice.
- The quantity of any drug requested on a private prescription must relate to the quantity on the PSD. So that if a PSD is made for a total of 45 units of botulinum toxin – A, the prescription must be for 50 units and not 100 units.
- A policy must be in place to ensure correct disposal of unused drugs.
Delegation and responsibilities

NMC prescribing standard 14

14.1 You may delegate the administration of a medication that you have prescribed. You remain accountable for your actions and you must be sure the person to whom you have delegated is competent and has received sufficient training to administer the prescribed medication.

NMC medicines management standard 25

Reporting adverse reactions

As a registrant, if a patient experiences an adverse drug reaction to a medication, you must take any action to remedy harm caused by the reaction. You must record this in the patient’s notes, notify the prescriber (if you did not prescribe the drug) and notify via the Yellow Card Scheme immediately.

BACN Best Practice.

- NMC guidelines are clear that the prescriber is accountable for the decision to prescribe and the non-prescriber is accountable for administration. Further, it is inherent in these guidelines that the non-prescriber has a duty to inform the prescriber of an adverse event and the prescriber has a duty to monitor and re-evaluate the patient.
- Best practice therefore would require the prescriber to prescribe for patients that are local to them, or be prepared to see patients at a distance at short notice.
- It is the prescribers responsibility to decide how best to evaluate the non-prescriber prior to delegation. Equally the non-prescriber should ascertain the experience of the prescriber and thus their ability to prescribe the drug and assist in dealing with adverse events.
- Both parties should satisfy themselves that NMC registration and prescribing status is in place.
- The prescribing nurse has the right to refuse their service based on such factors as:
  - Experience and capability of the injector
  - Standard of facilities and premises
  - Lack of concordance with protocols.
- Prescribing for adverse events which result from the initial prescription and treatment, would necessitate another face to face review.
Record keeping

NMC prescribing standard 7

7.1 The NMC Guidelines for records and record keeping provide the underlying principles

7.2 You should ensure records are accurate, comprehensive, contemporaneous and accessible by all members of a prescribing team (effective policies must be in place locally to enable this to happen)

BACN best practice

- A record of the PSD and prescription details should be made in the patient/client notes. In addition the prescriber should retain a copy of these for their records.
- Both nurses will sign the consultation/history sheet, together, upon completion.
- It is a legal responsibility that the client is protected under the Data Protection Act through notification to the Information Commissioner’s Office and records kept within these guidelines.

Assessment

NMC prescribing standard 3

3.1 In order to prescribe for a patient/client you must satisfy yourself that you have undertaken a full assessment of the patient/client, including taking a thorough history and, where possible, accessing a full clinical record.

BACN Best Practice

- The prescriber should undertake this medical history personally, rather than merely review a medical history already taken.
- It is expected that this would include a comprehensive medical history and physical assessment.
- The assessment will include the patient/client expectations and reasons for wanting treatment in the decision to prescribe.
Closing statement

It is hoped that the user of this document finds the individual sections useful in determining practice. However it is also hoped that the reader views the document as a whole in order to enhance their practice by virtue of its underlying principles.

These guidelines are based on the expertise and experience of a panel of members and contributors and benefits from the support of our industry partners. It is hoped therefore that it will inspire confidence and provide encouragement, permitting nurses to practice safely within guidelines imposed by their governing body and clarified by their peers.

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