

Chapter

Non-medical prescribing: an overview

Molly Courtenay and Matt Griffiths

In 1986, recommendations were made for nurses to take on the role of prescribing. The Cumberlege report, *Neighbourhood nursing: a focus for care* (Department of Health and Social Security (DHSS) 1986), examined the care given to clients in their homes by district nurses (DNs) and health visitors (HVs). It was identified that some very complicated procedures had arisen around prescribing in the community and that nurses were wasting their time requesting prescriptions from the general practitioner (GP) for such items as wound dressings and ointments. The report suggested that patient care could be improved and resources used more effectively if community nurses were able to prescribe as part of their everyday nursing practice, from a limited list of items and simple agents agreed by the DHSS.

Following the publication of this report, the recommendations for prescribing and its implications were examined. An advisory group was set up by the Department of Health (DoH) to examine nurse prescribing (DoH 1989). Dr June Crown was the Chair of this group.

The following is taken from the Crown report:

Nurses in the community take a central role in caring for patients in their homes. Nurses are not, however, able to write prescriptions for the products that are needed for patient care, even when the nurse is effectively taking professional responsibility for some aspects of the management of the patient. However experienced or highly skilled in their own areas of practice, nurses must ask a doctor to write a prescription. It is well known that in practice a doctor often rubber stamps a prescribing decision taken by a nurse. This can lead to a lack of clarity about professional responsibilities, and is demeaning to both nurses and doctors. There is wide agreement that action is now needed to align prescribing powers with professional responsibility (DoH 1989).

The report made a number of recommendations involving the categories of items which nurses might prescribe, together with the circumstances under which they might be prescribed. It was recommended that:

Suitably qualified nurses working in the community should be able, in clearly defined circumstances, to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol (DoH 1989).

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The Crown report identified several groups of patients that would benefit from nurse prescribing. These patients included: patients with a catheter or a stoma; patients suffering with postoperative wounds; and homeless families not registered with a GP. The report also suggested that a number of other benefits would occur as a result of nurses adopting the role of prescriber. As well as improved patient care, these included improved use of both nurses' and patients' time and improved communication between team members arising as a result of a clarification of professional responsibilities (DoH 1989).

During 1992, the primary legislation permitting nurses to prescribe a limited range of drugs was passed (Medicinal Products: Prescription by Nurses etc. Act 1992). The necessary amendments were made to this Act in 1994 and a revised list of products available to the nurse prescriber was published in the *Nurse Prescribers' Formulary* (NPF 2009). In 1994, eight demonstration sites were set up in England for nurse prescribing. By the spring of 2001, approximately 20 000 DNs and HVs were qualified independent prescribers and post-registration programmes for DNs and HVs included the necessary educational component qualifying nurses to prescribe. Later extensions (Nursing and Midwifery Council (NMC) 2005; 2007a) enabled any community nurse (including those without a specialist practitioner qualification) to prescribe from this formulary.

The available research exploring independent nurse prescribing by DNs and HVs indicates that patients are as satisfied, and sometimes more satisfied, with a nurse prescribing as they are with their GP. The quality of the relationship that the nurse has with the patient, the accessibility and approachability of the nurse, the style of consultation and information provided, and the expertise of the nurse are attributes of nurse prescribing viewed positively by patients (Luker et al. 1998). Nurse prescribing enables doctors and nurses to use their time more effectively and treatments are more conveniently provided (Brooks et al. 2001). Time savings and convenience (with regards to not seeing a GP to supply a prescription) are benefits reported by nurses adopting the role of prescriber (Luker et al. 1997). Furthermore, nurses are of the opinion that they provide the patient with better information about their treatment and have reported an increased sense of satisfaction, status and autonomy (Luker et al. 1997; Rodden 2001).

A further report by Crown, which reviewed the prescribing, supply and administration of medicines, was published in 1999 (DoH 1999). The review recommended that prescribing authority should be extended to other groups of professionals with training and expertise in specialist areas. During 2001, support was given by the Government for this extension (DoH 2001). Funding was made available for other nurses, as well as those currently qualified to prescribe, to undergo the necessary training to enable them to prescribe from an extended formulary.

This formulary included:

- A number of specified Prescription Only Medicines (POMs), enabling nurses to prescribe for a number of conditions listed within four treatment areas: minor ailments; minor injuries; health promotion; and palliative care.
- General Sales List (GSL) items, i.e. those that can be sold to the public without the supervision of a pharmacist, used to treat these conditions.
- Pharmacy (P) medicines, i.e. those products sold under the supervision of a pharmacist, used to treat these conditions.

A number of medicines and conditions were added to this formulary between 2003 and 2005 (including medicines for emergency and first contact care) until in 2006 legislation

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was passed (DoH 2005) enabling nurses to independently prescribe any licensed medicines for any condition within their area of competence and a number of controlled drugs.

Independent prescribing for pharmacists was introduced in 2006 (DoH 2005) and in 2009, further changes in legislation enabled nurse and pharmacist independent prescribers to prescribe unlicensed medicines for their patients and also to mix medicines themselves or direct others to do so (Medicines and Healthcare products Regulatory Agency (MHRA) 2009). At the time of publication of this book, restrictions around controlled drug (CD) prescribing for nurses and pharmacists were still in place. However, lifting of these restrictions is imminent, which will enable nurses and pharmacists to prescribe virtually any CD.

Independent prescribing for optometrists was introduced in 2007 (DoH 2007). Optometrists are able to prescribe any ophthalmic medication for any eye condition within their area of competence.

Supplementary prescribing

The introduction of a new form of prescribing for professions allied to medicine was suggested in 1999 (DoH 1999). It was proposed that this new form of prescribing, i.e. 'dependent prescribing', would take place after a diagnosis had been made by a doctor and a Clinical Management Plan (CMP) drawn up for the patient. The term 'dependent prescribing' has since been superseded by 'supplementary prescribing'.

Supplementary prescribing is 'a voluntary prescribing partnership between an independent prescriber (doctor) and a supplementary prescriber (SP) (nurse or pharmacist) to implement an agreed patient-specific CMP with the patient's agreement' (DoH 2002). Patients with long-term medical conditions such as asthma, diabetes or coronary heart disease, or those with long-term health needs such as anticoagulation therapy, are most likely to benefit from this type of prescribing.

Unlike independent prescribing, there are no legal restrictions on the clinical conditions for which SPs are able to prescribe. Supplementary prescribers are able to prescribe:

- All GSL and P medicines, appliances and devices, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All POMs (including CDs).
- 'Off-label' medicines (medicines for use outside their licensed indications), 'black triangle' drugs and drugs marked 'less suitable for prescribing' in the British National Formulary (BNF).

Unlicensed drugs may only be prescribed if they are part of a clinical trial with a clinical trial certificate or exemption (this may change following proposals set out by the MHRA (MHRA 2004) enabling SPs to prescribe unlicensed medicines).

Training for supplementary prescribing was introduced in 2003 for nurses and pharmacists (DoH 2002) and in 2005 for optometrists and allied health professionals (AHPs), i.e. physiotherapists, podiatrists/chiropractors and radiographers (DoH 2005).

Training is based on that for independent prescribing. The taught element of the course is 26/27 days, of which a substantial proportion is face-to-face contact time, although other ways of learning, such as open and distance learning (DL) formats, might be used. Students are also required to undertake additional self-directed learning and 12/13 days learning in practice with a medical prescriber.

Training for independent prescribing is now combined with that for SP in all higher education institutions (HEIs). The Royal Pharmaceutical Society of Great Britain (RPSGB 2003),

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which is responsible for validating SP programmes for pharmacists, has acknowledged that as 60–70% of the SP curriculum will be common to both nurses and pharmacists, institutions running the SP curriculum for nurses provide an ideal opportunity for shared learning. A number of HEIs run the combined independent/supplementary prescribing programme for nurses, pharmacists and AHPs. Nurses and pharmacists qualify as both independent and supplementary prescribers and AHPs as supplementary prescribers.

Educational preparation for extended prescribers

An outline curriculum for the educational preparation for independent prescribing was produced by the English National Board (ENB) in September 2001 (ENB 2006). Following the closure of the ENB, the NMC has continued to apply the ENB's existing standards and guidance for the approval of HEIs with regards to registerable and recordable programmes. Standards of proficiency for nurse and midwife prescribers were published in 2006 (NMC 2006).

A number of prerequisites are required by those who wish to undertake independent and supplementary prescribing training. These include:

- Registration with the NMC as a first level nurse or midwife or, for pharmacists, current registration with the RPSGB and/or the Pharmaceutical Society of Northern Ireland (PSNI). AHPs must be registered with the Health Professions Council in one of the relevant allied health professions legally able to prescribe.
- The ability to study at level 3 (degree level).
- At least three years' experience as a qualified nurse (the year immediately preceding application to the programme must be in the clinical field in which the candidate wishes to prescribe). For pharmacists, the level of relevant knowledge and expertise is dependent upon the nature of their practice and the length of their experience. AHPs must normally have at least three years of post-qualification experience.
- Agreement from a doctor that they will contribute to the 12/13 days learning in practice (including the assessment process), and post-qualifying experience.
- Employer's agreement to undertake the course and also that they will support continuing professional development (CPD).
- Commitment by their employer to enable access to prescribing budgets and other necessary arrangements for prescribing in practice.
- Occupation of a post in which they are expected to prescribe.

Nurses, pharmacists and AHPs must also be assessed by their employer as competent to take a history, and make a clinical assessment and diagnosis. Nurses and AHPs must also demonstrate appropriate numeracy skills.

The independent and supplementary prescribing training programme involves at least 26 days in the classroom (for distance learning programmes, eight taught days must be included in the programme) and 12 days in practice with a designated medical practitioner. Courses generally run over three to six months, but must be completed within one year. Topics taught include:

- Consultation skills.
- Influences on the psychology of prescribing.
- Prescribing in a team context.
- Clinical pharmacology.
- Evidence-based practice.

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- Legal, policy and ethical aspects.
- Professional accountability and responsibility.
- Prescribing in the public health context.

A range of assessments are used to assess students' knowledge and skills including a numeracy assessment in which a 100% pass rate must be achieved. In addition, nurses are required to demonstrate that they are aware of the anatomical and physiological difference between children and adults, are able to take an appropriate history and clinical assessment, and can make an appropriate decision to diagnose or refer (NMC 2007b).

Nurse prescribers are not required to undertake any additional hours of practice to meet CPD needs. However, appraisal of these needs should be undertaken on a yearly basis as part of performance review, and support to meet these needs must be provided by the nurse prescriber's employer (NMC 2008).

The combined independent and supplementary prescribing programme varies with regards to Credit Accumulation and Transfer (CAT) points awarded but is generally between 20 and 40 CAT points. In a number of universities and HEIs the prescribing module has been incorporated into post-qualification pathways such as the nurse practitioner course. In some of these instances, the number of academic credits are available at masters level.

For further discussion of supplementary prescribing see chapter 2.

Conclusion

The initial development of non-medical prescribing was slow. It was first considered by the Government for nurses in 1986 and the first formulary for DNs and HVs was extremely limited. Between 2002 and 2006 policy changes were rapid and nurses and pharmacists now have virtually the same prescribing rights as doctors. Although AHPs are currently restricted to supplementary prescribing, future policy changes will probably see the extension of independent prescribing rights to this group and the extension of supplementary prescribing to other healthcare professionals.

The delivery of healthcare within the United Kingdom is constantly changing. In order to ensure the survival of the National Health Service, and the development of future services, the skills of practitioners must be used appropriately. This means that where practitioners have the knowledge and skills with regards to the adoption of roles such as prescribing, and patients are happy with the services these practitioners are able to provide, they must be given the opportunity to do so.

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Chapter

2

Non-medical prescribing in a multidisciplinary team context

Barbara Stuttle

The demands by patients for a more streamlined, accessible and flexible service (Department of Health (DoH) 2000), demands for the integration of services (DoH 2008) and a high-quality accountable service, and demands for roles which extend beyond traditional boundaries acknowledging the range of knowledge and skills held by practitioners and offering them the opportunity to achieve their full potential (DoH 2001; 2002), have meant that the roles of healthcare professionals have changed dramatically over recent years. These changes have placed a great emphasis on teamwork and multiprofessional co-operation.

The success of non-medical prescribing is dependent upon the contributions from a number of practitioners, including specialist nurses, pharmacists and doctors, and the ability of these professionals to work together as a team. This chapter examines the key issues that need to be considered by healthcare professionals if non-medical prescribing is to be implemented effectively. It commences with an exploration of teamwork and then moves on to discuss clinical governance. Communication, sharing information and supplementary prescribing are then examined.

Teamwork

In order to work effectively as a team, a number of key elements are required. These include:

- Effective verbal and written communication.
- Enabling and encouraging supervision.
- Collaboration and common goals.
- Valuing the contributions of team members and matching team roles to ability.
- A culture that encourages team members to seek help.
- Team structure (Vincent et al. 1998).

Underpinning each of the above elements is the need for team members to have a clear understanding of one another's roles and the ability to communicate with one another. As non-medical prescribing has changed the role boundaries of professions allied to medicine, so the roles and relationships between healthcare professionals have changed. For example, the nurse adopting the role of prescriber affects the role of the pharmacist. The conversations surrounding medicines that once took place between the pharmacist and the doctor now take place between the pharmacist, doctor and nurse.

Conversely, it is important that the nurse is aware of the support the pharmacist is able to provide. This support will vary depending upon the environment within which the pharmacist works. If the pharmacist is working in a hospital setting and as a member of the ward team, they will have greater information about the patient's conditions and specific problems. The role of the pharmacist is therefore enhanced. As well as the interpretation of prescriptions,

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checking drug dosage levels and monitoring prescriptions for possible drug interactions, they may well be able to advise colleagues on a number of topics in relation to drug therapy, undertake medication reviews, discharge planning, education and training (Downie et al. 2003). Furthermore, with the introduction of independent and supplementary prescribing for pharmacists, pharmacists may well be leading clinics, such as anticoagulation or pain control clinics, and so be able to provide the nurse with a greater wealth of information and be an extremely useful resource in all aspects of prescribing and medicines management.

Another area in which confusion may occur, if roles are not fully understood, is levels of competency. For example, the ability of a nurse to prescribe means that they are able to carry out a complete episode of care. However, not all nurses within a team are qualified to prescribe. Therefore, there may be a lack of consistency or continuity of care if other non-prescribing nurses care for the patient. Unless these different levels of competency with regards to prescribing are understood between team members, this could result in inequity of service and confusion for the patient. It also needs to be clear who directs the care for the patient.

The advent of non-medical prescribing has therefore emphasised the need to clarify the activity of team members, i.e. those activities common to some professions, and those specific to the role of one discipline only. It has been suggested that without this clarity, team members might drift towards common ground and some areas of practice could become neglected (McCray 2002).

The core values of multidisciplinary work have been described as trust and sharing (Loxley 1997). An essential component of these values is that trust and sharing are a two-way process. Not only does the team rely on the individual's commitment to the task, but members must take on the team's belief in themselves and meet their expectations. If members of the team are to trust one another and share their experiences, confidence and a clear understanding of one's own professional role is essential (Loxley 1997).

For example, nurses have traditionally been seen as semi-autonomous practitioners working within the guidelines set by doctors. Medical staff have been seen as those making autonomous decisions and advising on practice. Some professions allied to medicine, e.g. physiotherapists, although practising autonomously, work primarily on an individual basis with clients. It is suggested by McCray (2002) that power and status, as a result of these differences, may well become an issue and influence trust and sharing when working together in a team. Doctors may well find it difficult to take advice from some healthcare professionals. By contrast, nurses may not feel confident enough to provide advice in relation to their own area of practice.

Clinical governance

Clinical governance has been defined as:

A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment to which excellence in clinical care will flourish (Scally and Donaldson 1998).

Clinical governance has been responsible for bringing professionals together as a multi-professional team, to collaborate and learn from each other. This has meant moving away from a culture of self-protection and blame, to one where self-regulation and learning through

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experience are valued (Jasper 2002). By working together and reflecting on the skills and knowledge of team members, the opportunities for progress and improvement in patient care are immense. The Bristol Royal Infirmary Inquiry (doh.gov.uk/bristol inquiry) and Victoria Climbié (<http://www.victoria-climbié-inquiry.org.uk/finreport/finreport.html>) provide examples of where teamwork and communication broke down. Recommendations from these reports focus on team working, communication, sharing information and joint learning.

Drug therapy is becoming increasingly complex. Many patients receive multiple drugs and therefore the possibility of error while administering medicines is large. An error that involves the administration of a drug can be a disaster for the patient. Drug administration generally involves several members of the multidisciplinary team and will include a chain of events involving several people, i.e. the manufacturer, distributor, pharmacist, prescriber, hospital managers and patient. A number of errors that may occur at each level have been identified by Downie et al. (2003). These include:

Prescriber error:

- Poor handwriting.
- Abbreviations.
- Confusion of product names that look similar.
- Omission of essential information.

Pharmacist error:

- Error in labelling medicines.
- Supply of medicines to wards without information on the actions, dose and use of the product.
- Lack of withdrawal of a product due to a fault, i.e. there is a need for rapid communication from pharmaceutical staff to ward staff.
- Lack of information about a product which is part of a clinical trial. If information is not supplied to ward staff involved in the trial, the product may not be used safely.

Error by the nurse administering the medicine:

- Misinterpretation of the prescription.
- Selection of the incorrect medicine to be administered.
- Inaccurate record of administration.

Error by the nurse manager:

- Lack of up-to-date drug information, i.e. BNF and local formularies unavailable.
- No clear lines of communication with clinical pharmacists and Medicines Information Service.
- Inappropriate staff members administering medicines.
- Inaccurate and illegible records regarding the drugs administered.
- Unsafe storage of medicines.
- Lack of withdrawal of medicines when no longer required.
- No consideration to timing and number of medicine rounds.

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Prescribing and recording documents not of the required standard and inappropriate for the area of practice.

Procedures used in the event of a drug error seen as a deterrent by nurses, i.e. a 'blame' culture.

An absence of a multidisciplinary drug and therapeutics committee to review medicines management issues.

Level of risk not assessed, i.e. some drugs more complicated to administer than others.

Patient error:

Lack of co-operation by the patient in order to achieve therapeutic benefits of the drug.

Rejection of treatment by the patient as a result of a lack of understanding (by the patient) about the drug therapy.

Clinical governance is a useful tool which can be used by the multidisciplinary team to maintain and improve the quality of non-medical prescribing and demonstrate that prescribing practice is in the best interests of the patient. It should ensure that each member of the prescribing team, i.e. doctor, nurse and pharmacist, recognises their role in providing high-quality patient care, and how the team can work together to improve prescribing standards.

Regular team meetings provide a forum in which members of the multidisciplinary team can work together to achieve common goals, and develop standards of care and protocols for prescribing. Within these meetings, awareness needs to be raised with regards to such systems as the Yellow Card Scheme for the spontaneous reporting of suspected adverse drug reactions by doctors, dentists, pharmacists, coroners and nurses (medicines.mhra.gov.uk), and the National Patient Safety Agency (NPSA) for reporting drug errors (www.npsa.nhs.uk). The NPSA hope that by promoting a fair and open culture in the NHS, staff will be encouraged to report incidents and so learn from any problems that affect the safety of patients. If team meetings raise staff awareness of the NPSA and errors are discussed, this will enable individuals to reflect and learn from mistakes and to take the appropriate action to prevent them happening again. There will be a move away from a 'blame' culture and patient safety will be increased.

Once standards of care have been set and implemented by members of the multiprofessional team, the team will be able to undertake periodic audits of prescribing practice. The outcome of these audits can be used to identify areas of prescribing practice that require improvement, and also the education and training needs of individuals. All healthcare professionals have a responsibility for their individual professional development and maintenance of prescribing knowledge. By working as a multiprofessional team, the needs of individuals can be identified, education and training programmes accessed, and learning shared across professional boundaries.

Communication and sharing information

The sharing of accurate information between multidisciplinary team members is vitally important. It was highlighted by the Crown report (DoH 1989) that good communication between health professionals and patients, and between different professionals, is essential for high-quality healthcare.

Good record keeping in relation to prescribing is essential and provides an efficient method of communication and dissemination of information between members of the