# Older Adults Division Non-Medical Prescribing Protocol

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Older Adults Division

Non-Medical Prescribing (NMP) Protocol

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1: Overview:
This Lincolnshire Partnership NHS Foundation Trust (LPFT) prescribing protocol is based on the holistic treatment within dementia and older adult mental health services which focuses on optimising physical and psychological health and social functioning. This approach includes emphasis on ensuring prescribing by non-medical prescribing (NMP) practitioners within the Services does not take place in isolation, but is a component of a broader care and treatment package. This approach aims to promote optimal health outcomes within dementia and all types of complex mental health related needs that considers all alternative options prior to the prescribing of medication.

2: The purpose of this document:
This protocol provides guidance for all NMP’s who work within the Older Adult Division who deliver clinical services to people experiencing dementia at any age and/or complex mental health needs in those of 65 years and above. This protocol enables all prescribers to formulate prescribing interventions consistent with best practice and LPFT’s Non-Medical Prescribing (NMP) policy (LPFT Medicines Management Policy - Appendix P).

3: Objectives of non-medical prescribing (NMP) within OAD:

- To support effective service delivery and clinical pathways that maximise operational and service user outcomes.
- To reduce waiting times for access to medications and optimise timely assessment to treatment outcomes.
- To ensure that service users are fully involved in decisions regarding their treatment and provided with sufficient and appropriate information to support decision making and collaborative management of their health and care needs.
- To prescribe in urgent situations, where it would be more beneficial and timely for a NMP to deliver the intervention.
- To ensure that all appropriate non-pharmacological options have been considered prior to/as part of any pharmacological treatment decision.
- To work with those service users who are assessed to be appropriate for intervention from a NMP as opposed to a psychiatrist (e.g. dispersed diagnosis associated treatment for non-complex dementia, non-complex MH needs, deprescribing etc.)
- To provide all treatment associated monitoring for service users under the care of a NMP. To include all associated physical health care (PHC) monitoring; including appropriate referrals and communications as a consequence of this monitoring.
- To reduce side-effects of medications through timely assessment and medication reviews in line with current best practice.
- To work within own competency and recognise professional limitations and make appropriate referral to medical prescriber when deemed necessary.
- To work with general practitioners and consultantant psychiatrists for the purposes of effective care and treatment delivery.
- To engage in collaborative care with service users as part of their treatment package. To improve overall medication concordance.
4: Basic operating principles of therapeutic NMP:

The following is a list of principles and practice of prescribing for NMP’s working within OAD falling under the remits of this protocol. Any deviation from these principles or modes of practice should first be sanctioned by the Clinical Director and Divisional Manager; who will keep the Chief Pharmacist informed of such matters.

- Service users, and where appropriate carers/advocate should be fully involved in all decisions about their treatment and be provided with sufficient information to make informed decisions and to support continued collaborative management of their health needs and associated outcomes.

- Prescribing interventions must be based upon a face-to-face assessment undertaken by the NMP.

- All NMP staff must ensure that they maintain their professional registration and any associated stipulations or conditions of registration (i.e. Continual Professional Development criteria).

- Locality team managers are responsible for ensuring that, they and all managed NMP staff are aware of and operate within the Trust NMP policy and Divisional NMP Protocol.

- NMP staff will work within the duties described within this document and the Trust Medicines Management (2a) (with specific reference to Appendix P – Non-Medical Prescribing Policy) and Medical Devices (2b) Policies.

- NMP’s should recognise their prescribing and other professional capabilities and act to ensure they are not working outside of these. They should discuss any concerns on such matters with their clinical supervisor.

- NMP’s must be satisfied that a comprehensive assessment, risk assessment and care-plan have been completed and are in date before any new prescription is started. The comprehensive assessment must include all relevant physical, psychological, and social problems and needs. Only if a comprehensive assessment indicates that the expected benefits of a prescribing outweigh its potential risks, will a prescription be issued.

- Before every new prescription is issued, the prescriber should be satisfied that each service user, or appropriate carer/advocate, is aware of the importance of monitoring medication and overall mental health to ensure effective and safe delivery of care.

- NMP’s should verify all service users and/or carer/advocate who are accessing prescribing services have been advised on safe storage arrangements for their prescription and risks to others, especially children, of having access to their prescribed medication.

- NMP’s should verify, where applicable, that service users and/or proxy/carers are informed about any driving regulations and if they should contact the Driving and Vehicle Licensing Agency (DVLA).

- Accurate, contemporaneous records must be kept of all prescriptions, including date issued, dates to start, drugs prescribed, and dosage.

- Green FP10 prescriptions should be used only when necessary/where prescribing via general practitioners by way of fax/e-mail is not a viable route. When an FP10 prescription is issued the NMP must ensure that they keep a record of all prescriptions issued and the serial numbers. These should be kept and stored in a safe place in accordance with Trust policy.

- Liaison between community pharmacies and NMP is fundamental for effective and safe treatment, as the pharmacist is usually the health care professional who has most regular (potentially daily)
contact with a service user. Prescribers should discuss all pharmacy issues with pharmacist and service users and/or proxy/carer.

- See ‘Review Process’ for timing and frequency of reviews by medical and NMP’s.

### 5: Referral criteria for NMP interventions:

In order for a service user to be eligible for NMP interventions they must meet the following criteria:

- The referral must fall within an area of practice approved by the Divisional Management Team for application of NMP.
- The service user must have an open referral to the OAD service within which the NMP practices.
- The service user, and/or proxy/carer, must be willing to engage with follow up care, if a pharmacological treatment is initiated.
- The referral must not present with complex needs falling outside of the agreed scope of NMP practice (e.g. complex physical health issues, multi-morbidities, etc) which may suggest that their needs would be met more appropriately by referral to a Consultant psychiatrist.
- The service user must have an up to date risk assessment and care plan in place prior to commencement of NMP activity.
- The referrer must provide the NMP with an up to date list of all physical and mental health medication and required PHC screening.

### 6: Scope of Prescribing Practice – including restrictions:

All independent and supplementary NMP’s must only agree/have a professional responsibility and accountability, to prescribe medication or products they are satisfied fall within their area of clinical competence and experience, and within the remit of their job description/role profile and the service within which they are employed (see section 3.2.1. of LPFT Medicines Management Policy (2a) Appendix P).)

With OAD prescribing for all independent and supplementary NMP’s is only supported within/is restricted to: Section 4 (Nervous System) of the British National Formulary (BNF) within the identified sub-categories (all up to BNF limits for elderly): within section 4 restrictions/exclusions available for NMP are identified below in *parentheses.

**NMP Core Principles**

- **Oral routes of administration only** (with exception of Rivatigmine transdermal patch)

- Conditions and needs related to:
  - non-complex mental health needs in the elderly
  - non-complex dementia associated needs of any age.
Further restrictions placed on the extent of independent prescribing practice as agreed with their clinical supervisor. This is particularly likely for newly qualified NMP’s, and those who have cumulated little prescribing experience. The extent of clinical prescribing practice for each individual NMP must be agreed within clinical supervision with direct reference and accord for both this Operational Protocol and the Trust NMP Clinical Scope of Practice guidelines. The agreed scope then needs to be explicitly recorded within the supervision notes.

The parameters for prescribing are then approved with the Clinical Director and Divisional manager. The locality team manager must be aware of the agreed parameters of professional/clinical practice and keep a record of the agreed practice parameters within the approved prescribers staff file.

7: Formulary of prescribing by NMP’s:

As per section 6 (above) NMP is restricted to section 4 of the BNF. Prescribing practice must be supported/guided by the guidance within current BNF editions for this section (4).

NMP’s within the OAD also need to be aware of work within the parameters of additional prescribing guidance of specific relevant to OAD clinical teams:

Prescribing related to:

- Any Shared Care Guidance (SCG) requirements – see Dementia-shared-care-guidance

Further guidance on good prescribing practice is available within;

- LPFT’s Medicines Management (2a) and Medical Devices (2b) Policies.
- The current edition BNF.
- BNF online icon link on Trust home screens > [https://www.medicinescomplete.com/mc/bnf/current/](https://www.medicinescomplete.com/mc/bnf/current/)
8: Clinical pathway from medical prescribing to NMP:

This section relates to NMP’s, who may be eligible to receive cases as a transfer from medical prescribers only if specified within the NMP’s job role.

- Service users will be eligible for transfer when the clinical presentation is consistent with agreed scope of practice for relevant individual NMP.
- The service user has been fully consulted/informed and is in agreement with the transfer of care.
- The transfer must be jointly agreed between the transferring (i.e. medical) and receiving (i.e. non-medical) prescriber.

Transfer to a newly qualified NMP, and to those who have cumulated little prescribing experience, should only be considered for service users who are clinically ‘stable’; as indicated by all of the following:-

- Regular attendance for appointments.
- No evidence of a pattern of problematic use of prescription drugs or illicit drugs.
- No evidence of heavy or problematic drinking.
- No current acute mental health disorder.
- No severe or deteriorating physical problems that complicate drug treatment, to include pregnancy.

9: Clinical pathway from NMP to medical prescribing:

The following presenting features should trigger a discussion between a NMP and a medical prescriber about a return of prescribing to/enhanced support from the latter:

- Deteriorating physical health/complex physical co-morbidities.
- Mental health/dementia related needs with complex/unstable co-morbid neurological conditions (e.g. epilepsy/seizures, Parkinson’s disease (PD’s), Huntington’s disease (HD) etc.).
- Complex/treatment resistant mental health conditions requiring complex dual/adjunctive therapy; i.e. two classes of drugs from within the same drug group (e.g. antidepressants, antipsychotics etc.).
- Treatment resistant/refractory depression where a monoamine oxidase inhibitor (MAOI) is to be considered/indicated.
- Evidence of heavy or problematic use of other substances, including alcohol.
- Recurrent failure to engage with NMP and/or attend appointments.
- When a possible increase of medication, which would exceed BNF limits, is indicated/required.
- Any other presenting feature that causes the NMP to feel concerned about lack of progress or level of risks/falling outside of their scope of practice competence.

It is not intended that service users repeatedly bounce between non-medical and medical prescribers. Most discussions between a NMP and a medical prescriber (including the clinical lead) about ‘unstable’ service
users will result in advice only, but some discussions will result in the medical prescriber providing a single assessment appointment, and in these situations, the service user remains under the care of the NMP.

When one or more of the above criteria is/are clearly present, and unlikely to resolve quickly, discussion between a NMP and a medical prescriber (including the clinical lead) may result in a transfer of the prescribing responsibilities to the medical prescriber. These service users will remain under the care of the medical prescriber until their presentations are consistent with the criteria for being managed by a NMP; hence, there is no minimum or maximum time for service users to stay with a medical prescriber.

10: Review process:

NMP’s should be care-coordinators for all service users to whom they prescribe.

NMP’s should routinely review the response and health status of all service users for who they prescribe in line with current best-practice guidelines. A review appointment should occur no longer than between 2 and 4 weeks (medication dependent) following the initiation of a new medication.

Routine monitoring, i.e. of established/stabilised medication, should take place at minimum every 12 weeks*. However, in the event of an urgent appointment being required, all attempts will be made to facilitate this.

- *All reviews of antipsychotics must be recorded of the Service Anti-psychotic review template within the patient notes on the clinical system.

Failure to attend a clinic-based review with any NMP, will result in one further appointment being offered. If the service user fails to attend without informing the team, resulting in a DNA, a discussion with a medical prescriber regarding discharge back to the care of the general practitioner will take place.

11: Physical health care (PHC) screening/monitoring:

The NMP will take responsibility for ensuring the regular completion of appropriate required monitoring for specific and general recommended medication monitoring and associated/indicated PHC needs.

These include:

- Ensuring all new referrals have completed the OAD PHC screening assessment.
- Reviewing results and liaising with medical staff to interpret findings. To make appropriate onwards referrals as required.
- Ensuring physical health checks are completed prior to drug initiation and on a regular basis as indicated by best-practice; such as BMI, blood work (e.g. FBC’s, U&E’s etc.) blood pressure, pulse etc.
- Take appropriate account within prescribing choices of existing PHC issues impacting drug response (e.g. hepatic and renal function).
- Making referral to other health care providers such as dietitians, SALT, smoking cessation etc. as required/indicated.
Specific PHC-monitoring requirements related to the treatment for the management of behaviours that challenge (BC’s) in dementia and/or delirium and for Rapid Tranquillisation for frail Adults as per additional guidance (see section 7 above).

12: Adverse drug reactions (ADR’s):

The NMP has a duty to report any adverse drug reactions via the yellow card system (for reporting cards see inside cover of BNF) and also alert to consultant, GP and any other health care professional including the pharmacist.

13: Black triangle drugs:

The NMP can prescribe black triangle drugs but this must be discussed with a consultant or medical prescriber especially if initiating the medication.

14: Prescribing above BNF limits and “off licence drugs”:

Any drugs prescribed over the BNF limits will only be prescribed within a Clinical management plan with the consultant psychiatrist maintaining overall responsibility.

Prescribing “off licence” will only be exercised with careful consideration and liaison with the consultant psychiatrist. Clear rationale for the prescribing decision must be fully documented in the clinical record.

15: Supervision:

NMP’s should have regular supervision from either a consultant psychiatrist or a senior, experienced NMP. Supervision sessions involve a 1 hour meeting and occur at a frequency of 4 to 6 weekly for NMP’s. The supervision record should contain:

- Topics raised in advance by supervisor.
- Topics raised in advance by supervisee.
- Topics discussed.
- Outcome actions for supervisor.
- Outcome actions for supervisee.
- Date of next supervision.

Once the content of the written record is agreed by supervisor and supervisee, it is signed by both.

It is also recommended that all NMP’s become members of the Trust NMP forum to support clinical practice and ongoing CPD requirements.
**Appendix 1: Use of Anti-Psychotic Interventions in Dementia best practice guidelines**

### 1: Indication for use: (NICE ng97)

Antipsychotics should only be used for people with dementia presenting with Severe distress and/or immediate risk of harm to self or others. Those presenting with mild-to-moderate non-cognitive symptoms should not be prescribed anti-psychotic drugs due to increased risk of cerebrovascular adverse effects and death.

### 2: Consideration:

Before prescribing antipsychotic medication for BPSD, likely factors that may generate, aggravate or improve such behaviours (and associated needs) should be assessed and/or considered (see Clinical pathway).

### 3: Treatment: (NICE ng97)

| Target symptoms should be identified, quantified via NPI, and clearly documented in clinical notes if AP’s are prescribed, of how long treatment is to be used and review frequency. |
| Clinical measure: Service Standard |
| Neuropsychiatric Inventory (NPI) |

#### 3.1: Target symptoms should be identified, quantified via NPI, and documented in clinical notes.

#### 3.2: Cerebrovascular risk factors should be assessed.

#### 3.3: The effect of comorbid conditions, such as depression, should be considered.

#### 3.4: Full discussion with SU and/or carers about possible;
- In particular cerebrovascular risks factors and possible risk of stroke/ischaemic attack and possible adverse effects on cognition.

#### 3.5: Changes in cognition should be assessed and recorded on regular intervals.

#### 3.6: The medication review should take account of;
- Therapeutic response
- Possible adverse effects
- Start at lowest possible dose and gradually increase only if necessary to minimum therapeutic dose.
- Increase every 2-4 days if no response
- Once patient has responded maintain for up to 6 weeks then withdraw by halving dose for one week then stop if no symptoms. Review again in 7 days.
- PRN medication should be reviewed at least every 7 days.

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**Also**

- The capacity of the person with dementia must be assessed in relation to treatment decision making

**MCA**

- If medication to be administered covertly to undertake a BI meeting, fully care plan and regular review

**Covert**

- **REMEMBER**

**Patient/service user engagement**

- At minimum every 6 weeks
- Outcome of review must be documented in the clinical records > on the OA AP review notes template
- LPFT Medicine chart

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<th><strong>3.7:</strong></th>
<th>The dose should be low initially and then titrated upwards.</th>
<th>LPFT prescription card</th>
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Treatment should be time-limited and regularly reviewed: *(minimum every 6 weeks or according to clinical need).*

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Appendix 2: Clinical Management Plan (CMP) for supplementary prescribing:

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<th>Name of patient:</th>
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Patient identification e.g. ID number, date of birth:

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<th>Current medication:</th>
<th>Medical history:</th>
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Independent Prescriber(s):

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Supplementary Prescriber(s):

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Condition(s) to be treated:

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<th>Aim of treatment:</th>
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**Medicines that may be prescribed by SP:**

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<th>Preparation:</th>
<th>Indication:</th>
<th>Dose schedule:</th>
<th>Specific indications requiring referral back to IP:</th>
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Guidelines or protocols supporting clinical management plan:

Frequency of review and monitoring by:

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<th>Supplementary prescriber or independent prescriber:</th>
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Process for reporting ADRs:

Shared record to be used by IP and SP:

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<th>Agreed by independent prescriber(s):</th>
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