**APPENDIX 7**

**NON-MEDICAL PRESCRIBING SCOPE OF PRACTICE DOCUMENT**

**This scope of practice statement should be completed by all non-medical prescribers holding the V300 qualification (Nurse Independent/Supplementary Prescriber) and all other professionals holding a non-medical prescriber qualification:**

* For governance purposes to monitor against your prescribing data
* To be used during your appraisal as a tool to plan your development as a prescriber,
* To provide assurance to the organisation that the practitioner has attained the necessary competencies

|  |  |
| --- | --- |
| **Name as registered with Professional Body:** |  |
| **Job role / Designation:** |  |
| **Professional Registration (PIN)** |
| **Work base:**  |  |
| **Directorate / Team / Ward / Locality** |  |
| **Trust Email Address & Mobile number:**  |  |

**Please complete this form (including the table listing areas of practice), and sign/date in the space below.**

**One copy of the completed form should be sent to the Non-Medical Prescribing Lead and one copy retained by the Line Manager. Areas of competence can be listed as disease areas/prescribing speciality or refer to specific section(s)/sub-section(s) of the BNF. This agreement must be reviewed every two years and updated when the practitioners scope of practice changes.**

**My intended scope of practice and prescribing parameters have been discussed with my line manager as part of my Appraisal:**

|  |  |  |
| --- | --- | --- |
| **Full Name** | **Signature** | **Date** |

**Non-Medical**

**Prescriber**

**Line Manager**

**……see overleaf for completion of Prescribing Scope**

**Non-Medical Prescribing - Scope of Practice and Prescribing Parameters**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease area to be** | **Evidence of** | **Use of Prescribing Authority** |  |  |
| **prescribed for or category of** | **Competence to** | (√ in the appropriate section) |  |  |
| **medicines to be prescribed** | **Prescribe in this** |  |  |  |  |
| **e.g. palliative care,** | **Area\*\*** |  |  |  |  |
| **antibiotics** |  |  |  |  |  |
|  |  | **Diagnose &** | **Initiate after** | **Titrate/adjust** | **Continue therapy** |
|  |  | **initiate treatment** | **diagnosis** | **doses** | **without dose adjustment** |
|  |  |  |  |  |  |
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**\*\* Evidence of competence will be requested by line manager for submission to Local NMP Lead.**