QUESTIONS ABOUT PATIENT SPECIFIC DIRECTIONS

The following Q&As are intended to be read as a complete document to help provide the full context in practice.

The term “prescriber” refers to doctors, dentists, and all other registered health professionals who are qualified independent or supplementary prescribers.

Good practice principles for prescribing are the same for all prescribers.

What is a Patient Specific Direction (PSD)?

A Patient Specific Direction (PSD) is the traditional written instruction, signed by a doctor, dentist, or non-medical prescriber (hereafter referred to as “the prescriber” unless stated otherwise) for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. (1)

Where a Patient Specific Direction exists, there is no need for a Patient Group Direction (PGD).

In practice, we know that a PSD is commonly referred to as a prescription by those who write and follow them because this indicates that it is written by a prescriber.

Does a PSD need to be written?

Yes. A PSD must be written and signed by the prescriber (2).

A verbal instruction is not a valid PSD (3).

If a prescriber writes a PSD, are they prescribing?

Yes.

A prescriber makes a decision based on the knowledge of an individual patient assessment, and the written instruction for the supply and/or administration of the medicine is individually tailored to the needs of that patient. (3,4,5)

What should the PSD include?

The information required in a PSD for administration of a medicine at a minimum should include (3,5):

Name of patient and/or other individual patient identifiers
Name, form and strength of medicine (generic or brand name where appropriate)
Route of administration
Dose
Frequency
Start and finish dates.
Signature of prescriber.

A PSD is individually tailored to the needs of a single patient so more information may be required to enable safe supply and/or administration of some medicines and to manage identified risks.

A PSD for the supply of medicines is classified as a prescription form. This form is a legal document and must comply with the requirements for prescriptions as specified in the Human Medicines Regulations 2012 (2). For example, a PSD for supply of medicines to be dispensed for a patient to take home from hospital is a prescription form.

If a PSD is for supply of a controlled drug, the form should also meet the legal requirements for hand-writing CD prescriptions.
Can the prescriber write a PSD remotely without a face-to-face consultation with the patient?

Prescribers should refer to their professional regulatory body for advice if they are considering the need to write a PSD remotely during their practice.

General Medical Council (GMC) provides guidance for remote prescribing via telephone, video-link or online (3). This guidance also states that a physical examination of patients by a doctor must take place before prescribing non-surgical cosmetic medicinal products such as Botox, Dysport or Vistabel or other injectable cosmetic medicines (3). See also MHRA guidance (6).

The Nursing and Midwifery Council (NMC) Standards of Proficiency for Nurse and Midwife Prescribers (7) states that where a medication has not been prescribed before, a nurse or midwife independent prescriber may not prescribe remotely if they have not assessed the patient, except in life-threatening situations.

How long is a PSD valid for?

There is no legally valid period for a PSD for administration of a medicine. The prescriber should include a start and finish date in the direction to ensure it is acted on within a time frame following assessment which is appropriate to the needs of the patient.

A PSD for the supply of medicines is classified as a prescription form. This form is a legal document and supply must comply with the requirements for prescriptions.

Local procedures should be agreed to address any delay and action to be taken by the person who may be supplying and/or administering the medicine.

Appropriate measures should be taken to ensure that the supply and administration of that medicine remains safe to the point of administration and beyond e.g. following local guidelines on correct administration and monitoring for medicines supplied or administered.

Can a prescriber write a PSD and then supply and/or administer the medicine?

There should, where ever possible, be separation of prescribing and supply/administration roles. (7,8).

Standards for the safe and secure handling of medicines must also be considered. (9)

What are the responsibilities and accountabilities of the prescriber who writes the PSD? (amended July 2015)

The prescriber is responsible for assessment of the patient and the decision to supply/administer the medicine(s) in question. The prescriber has a duty of care and is professionally and legally accountable for the care he/she provides.

The prescriber must be satisfied that the person to whom practice is delegated has the qualifications, experience, knowledge and skills to provide the care or treatment involved. (10, 11)
What clinical governance arrangements should be in place?

Whilst, in law, anyone may follow a PSD, some organisations may extend or limit those who are authorised to supply or administer medicines under a PSD within their local medicines policies and governance arrangements.

The employing organisation has a duty of care to both the patient and to the staff and is responsible for ensuring that the staff it employs are properly trained and undertake only those responsibilities specified in agreed job descriptions. If expecting non-regulated staff e.g. healthcare assistants to administer medicines, those delegating the duty must ensure that the non-regulated staff are competent to do so safely.

PSDs may need to be supported by a locally approved procedure or guideline to support safe administration of the medicine by an appropriately trained and competent healthcare professional (9).

Prescribers and anyone administering or supplying medicines must ensure that they adhere to clinical governance policies and procedures and associated arrangements.

What are the accountabilities and responsibilities of the delegated staff?

A person who supplies or administers a medicine is accountable for their own practice (5) and must be trained and competent to undertake such tasks.

They must act according to their level of competence and in accordance with the directions of the prescriber.

Examples of PSDs

- an instruction to administer a medicine, written in the patient's notes or, in acute care, this might be an instruction written on an inpatient's medicine chart (1). Careful consideration needs to be given to how the instruction is incorporated in the patient record to ensure that the medicine is given safely and in a timely manner.

- an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber. The prescriber must have adequate knowledge of the patient's health, and be satisfied that the medicine to be administered serves the individual needs of each patient on that list.

The following are not PSDs and are not a legal authority for the administration or supply of medicines:

- A Patient Group Direction (PGD) template developed and renamed a “PSD” for use by healthcare staff.

- An instruction applying to any patient who may be seen by a healthcare professional or who has an appointment on any particular day.

- A verbal instruction.
QUESTIONS ABOUT PATIENT SPECIFIC DIRECTIONS

REFERENCES


6. MHRA. Supply and administration of Botox®, Vistabel®, Dysport® and other injectable medicines outside their licensed medicinal uses such as in cosmetic procedures. 2005 http://www.mhra.gov.uk/Howweregulate/Medicines/Availabilityprescribingandsupplyingofmedicines/Frequentlyraisedissues/BotoxVistabelDysportandotherinjectablemedicinesincosmeticprocedures/index.htm?q7


Reviewed and updated by Angela Bussey PGD Website Specialist Pharmacist in association with the PGD Website Board. Adapted from original version by Alison Dale, February 2009. Clinical and Education Development Lead, Y&H SHA. Published March 2013. Minor amendments July 2015. Review by March 2018 or earlier subject to legislation or guidance changes.

If you are referring to a hard copy of this document – please check the PGD website to make sure that you are using the most recent version.