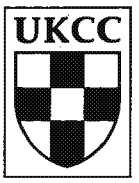

Standards for the Administration of Medicines

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

October 1992

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

23 Portland Place, London W1N 3AF
Telephone 071-637 7181 Facsimile 071-436 2924

List of Contents

Introduction Paragraphs 1 to 4

Treatment with medicines Paragraph 5

Prescription Paragraph 6

Dispensing Paragraph 7

Standards for the administration of medicines Paragraphs 8 to 11

Applying the standards in a range of settings Paragraphs 12 to 32

- Who can administer medicines? Paragraph 12
- Administration in the hospital setting Paragraphs 13 to 16
- Administration in the domestic or quasi-domestic setting Paragraphs 17 to 18
- Self-administration of medicines in hospitals or registered nursing homes Paragraphs 19 to 22
- The use of monitored dosage systems Paragraphs 23 to 27
- The role of nurses, midwives and health visitors in community practice in the administration of medicines Paragraphs 28 to 32

Midwives and midwifery practice Paragraph 33

What if the Council's standards in paragraphs 8 to 11 cannot be applied? Paragraphs 34 to 36

Substances for topical application Paragraph 37

The administration of homeopathic or herbal substances Paragraph 38

Complementary and alternative therapies Paragraph 39

Practitioners assuming responsibility for care which includes medicines being administered which were previously checked by other practitioners Paragraph 40

Management of errors or incidents in the administration of medicines Paragraphs 41 to 43

Future arrangements for prescribing by nurses Paragraph 44

Introduction

1 This standards paper replaces the Council's advisory paper 'Administration of Medicines' (issued in 1986) (1) and the supplementary circular 'The Administration of Medicines' (PC 88/05) (2). The Council has prepared this paper to assist practitioners to fulfil the expectations which it has of them, to serve more effectively the interests of patients and clients and to maintain and enhance standards of practice.

2 The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner. It requires thought and the exercise of professional judgement which is directed to:

2.1 confirming the correctness of the prescription;

2.2 judging the suitability of administration at the scheduled time of administration;

2.3 reinforcing the positive effect of the treatment;

2.4 enhancing the understanding of patients in respect of their prescribed medication and the avoidance of misuse of these and other medicines and

2.5 assisting in assessing the efficacy of medicines and the identification of side effects and interactions.

3 To meet the standards set out in this paper is to honour, in this aspect of practice, the Council's expectation (set out in the Council's 'Code of Professional Conduct') (3) that:

"As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1 act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;

2 ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;

3 maintain and improve your professional knowledge and competence;

4 acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner;"

4 This extract from the 'Code of Professional Conduct' applies to all persons on the Council's register irrespective of the part of the register on which their name appears. Although the content of pre-registration education programmes varies, dependent on the part and level of the register involved, the Council expects that, in this area of practice as in all others, all practitioners will have taken steps to develop their knowledge and

competence and will have been assisted to this end. The word 'practitioner' is, therefore, used in the remainder of this paper to refer to all registered nurses, midwives and health visitors, each of whom must recognise the personal professional accountability which they bear for their actions. The Council therefore imposes no arbitrary boundaries between the role of the first level and second level registered practitioner in this respect.

Treatment with Medicines

5 The treatment of a patient with medicines for therapeutic, diagnostic or preventative purposes is a process which involves prescribing, dispensing, administering, receiving and recording. The word 'patient' is used for convenience, but implies not only a patient in a hospital or nursing home, but also a resident of a residential home, a client in her or his own home or in a community home, a person attending a clinic or a general practitioner's surgery and an employee attending a workplace occupational health department. 'Patient' refers to the person receiving a prescribed medicine. Each medicine has a product licence, which means that authority has been given to a manufacturer to market a particular product for administration in a particular dosage range and by specified routes.

Prescription

6 The practitioner administering a medicine against a prescription written by a registered medical

practitioner, like the pharmacist responsible for dispensing it, can reasonably expect that the prescription satisfies the following criteria:

6.1 that it is based, whenever possible, on the patient's awareness of the purpose of the treatment and consent (commonly implicit);

6.2 that the prescription is either clearly written, typed or computer-generated, and that the entry is indelible and dated;

6.3 that, where the new prescription replaces an earlier prescription, the latter has been cancelled clearly and the cancellation signed and dated by an authorised registered medical practitioner;

6.4 that, where a prescribed substance (which replaces an earlier prescription) has been provided for a person residing at home or in a residential care home and who is dependent on others to assist with the administration, information about the change has been properly communicated;

6.5 that the prescription provides clear and unequivocal identification of the patient for whom the medicine is intended;

6.6 that the substance to be administered is clearly specified and, where appropriate, its form (for example tablet, capsule, suppository) stated, together with the strength,

dosage, timing and frequency of administration and route of administration;

6.7 that, where the prescription is provided in an out-patients or community setting, it states the duration of the course before review;

6.8 that, in the case of controlled drugs, the dosage is written, together with the number of dosage units or total course if in an out-patient or community setting, the whole being in the prescriber's own handwriting;

6.9 that all other prescriptions will, as a minimum, have been signed by the prescribing doctor and dated;

6.10 that the registered medical practitioner understands that the administration of medicines on verbal instructions, whether she or he is present or absent, other than in exceptional circumstances, is not acceptable unless covered by the protocol method referred to in paragraph 6.11;

6.11 that it is understood that, unless provided for in a specific protocol, instruction by telephone to a practitioner to administer a previously unprescribed substance is not acceptable, the use of facsimile transmission (fax) being the preferred method in exceptional circumstances or isolated locations and

6.12 that, where it is the wish of the professional staff concerned that practitioners in a particular setting be authorised to administer, on their own authority, certain medicines, a local protocol has been agreed between medical practitioners, nurses and midwives and the pharmacist.

Dispensing

7 The practitioner administering a medicine dispensed by a pharmacist in response to a medical prescription can reasonably expect that:

7.1 the pharmacist has checked that the prescription is written correctly so as to avoid misunderstanding or error and is signed by an authorised prescriber;

7.2 the pharmacist is satisfied that any newly-prescribed medicines will not dangerously interact with or nullify each other;

7.3 the pharmacist has provided the medicine in a form relevant for administration to the particular patient, provided it in an appropriate container giving the relevant information and advised appropriately on storage and security conditions;

7.4 where the substance is prescribed in a dose or to be administered by a route which falls outside its product licence, unless to be administered from a stock supply, the pharmacist

will have taken steps to ensure that the prescriber is aware and has chosen to exceed that licence;

7.5 where the prescription for a specific item falls outside the terms of the product licence, whether as to its route of administration, the dosage or some other key factor, the pharmacist will have ensured that the prescriber is aware of this fact and, mindful of her or his accountability in the matter, has made a record on the prescription to this effect and has agreed to dispense the medicine ordered;

7.6 if the prescription bears any written amendments made and signed by the pharmacist, the prescriber has been consulted and advised and the amendments have been accepted and

7.7 the pharmacist, in pursuit of her or his role in monitoring the adverse side-effects of medicines, wishes to be sent any information that the administering practitioner deems relevant.

Standards for the Administration of Medicines

8 Notwithstanding the expected adherence by registered medical practitioners and pharmacists to the criteria set out in paragraphs 6 and 7 of this paper, the nurse, midwife or health visitor must, in administering

any medicines, in assisting with administration or overseeing any self-administration of medicines, exercise professional judgement and apply knowledge and skill to the situation that pertains at the time.

9 This means that, as a matter of basic principle, whether administering a medicine, assisting in its administration or overseeing self-administration, the practitioner will be satisfied that she or he:

9.1 has an understanding of substances used for therapeutic purposes;

9.2 is able to justify any actions taken and

9.3 is prepared to be accountable for the action taken.

10 Against this background, the practitioner, acting in the interests of the patients, will:

10.1 be certain of the identity of the patient to whom the medicine is to be administered;

10.2 ensure that she or he is aware of the patient's current assessment and planned programme of care;

10.3 pay due regard to the environment in which that care is being given;

10.4 scrutinise carefully, in the interests of safety, the prescription, where available, and the information provided on the relevant containers;

10.5 question the medical practitioner or pharmacist, as appropriate, if the prescription

or container information is illegible, unclear, ambiguous or incomplete or where it is believed that the dosage or route of administration falls outside the product licence for the particular substance and, where believed necessary, refuse to administer the prescribed substance;

10.6 refuse to prepare substances for injection in advance of their immediate use and refuse to administer a medicine not placed in a container or drawn into a syringe by her or him, in her or his presence, or prepared by a pharmacist, except in the specific circumstances described in paragraph 40 of this paper and others where similar issues arise and

10.7 draw the attention of patients, as appropriate, to patient information leaflets concerning their prescribed medicines.

11 In addition, acting in the interests of the patient, the practitioner will:

11.1 check the expiry date of any medicine, if on the container;

11.2 carefully consider the dosage, method of administration, route and timing of administration in the context of the condition of the specific patient at the operative time;

11.3 carefully consider whether any of the prescribed medicines will or may dangerously interact with each other;

11.4 determine whether it is necessary or advisable to withhold the medicine pending consultation with the prescribing medical practitioner, the pharmacist or a fellow professional colleague;

11.5 contact the prescriber without delay where contra-indications to the administration of any prescribed medicine are observed, first taking the advice of the pharmacist where considered appropriate;

11.6 make clear, accurate and contemporaneous record of the administration of all medicines administered or deliberately withheld, ensuring that any written entries and the signature are clear and legible;

11.7 where a medicine is refused by the patient, or the parent refuses to administer or allow administration of that medicine, make a clear and accurate record of the fact without delay, consider whether the refusal of that medicine compromises the patient's condition or the effect of other medicines, assess the situation and contact the prescriber;

11.8 use the opportunity which administration of a medicine provides for emphasising, to patients and their carers, the importance and implications of the prescribed treatment and for enhancing their understanding of its effects and side-effects;

11.9 record the positive and negative effects of the medicine and make them known to the prescribing medical practitioner and the pharmacist and

11.10 take all possible steps to ensure that replaced prescription entries are correctly deleted to avoid duplication of medicines.

Applying the Standards in a Range of Settings

Who can administer medicines?

12 There is a wide spectrum of situations in which medicines are administered ranging, at one extreme, from the patient in an intensive therapy unit who is totally dependent on registered professional staff for her or his care to, at the other extreme, the person in her or his own home administering her or his own medicines or being assisted in this respect by a relative or another person. The answer to the question of who can administer a medicine must largely depend on where within that spectrum the recipient of the medicines lies.

Administration in the hospital setting

13 It is the Council's position that, at or near the first stated end of that spectrum, assessment of response to treatment and speedy recognition of contra-indications and side-effects are of great importance. Therefore prescribed medicines should only be administered by registered practitioners who are competent for the purpose and aware of their personal accountability.

14 In this context it is the Council's position that, in the majority of circumstances, a first level registered nurse, a midwife, or a second level nurse, each of whom has demonstrated the necessary knowledge and competence, should be able to administer medicines without involving a second person. Exceptions to this might be:

14.1 where the practitioner is instructing a student;

14.2 where the patient's condition makes it necessary and

14.3 where local circumstances make the involvement of two persons desirable in the interests of the patients (for example, in areas of specialist care, such as a paediatric unit without sufficient specialist paediatric nurses or in other acute units dependent on temporary agency or other locum staff).

15 In respect of the administration of intravenous drugs by practitioners, it is the Council's position that this is acceptable, provided that, as in all other aspects of practice, the practitioner is satisfied with her or his competence and mindful of her or his personal accountability.

16 The Council is opposed to the involvement of persons who are not registered practitioners in the administration of medicines in acute care settings and with ill or dependent patients, since the requirements of paragraphs 8 to 11 inclusive of this paper cannot then be

satisfied. It accepts, however, that the professional judgement of an individual practitioner should be used to identify those situations in which informal carers might be instructed and prepared to accept a delegated responsibility in this respect.

Administration in the domestic or quasi-domestic setting

17 It is evident that in this setting, on the majority of occasions, there is no involvement of registered practitioners. Where a practitioner engaged in community practice does become involved in assisting with or overseeing administration, then she or he must observe paragraphs 8 to 11 of this paper and apply them to the required degree. She or he must also recognise that, even if not employed in posts requiring registration with the Council, she or he remains accountable to the Council.

18 The same principles apply where prescribed medicines are being administered to residents in small community homes or in residential care homes. To the maximum degree possible, though related to their ability to manage the care and administration of their prescribed medicines and comprehend their significance, the residents should be regarded as if in their own home. Where assistance is required, the person providing it fills the role of an informal carer, family member or friend. However, as with the situation described in paragraph 17, where a professional practitioner is involved,

a personal accountability is borne. The advice of a community pharmacist should be sought when necessary.

Self-administration of medicines in hospitals or registered nursing homes

19 The Council welcomes and supports the development of self-administration of medicines and administration by parents to children wherever it is appropriate and the necessary security and storage arrangements are available.

20 For the hospital patient approaching discharge, but who will continue on a prescribed medicines regime following the return home, there are obvious benefits in adjusting to the responsibility of self-administration while still having access to professional support. It is accepted that, to facilitate this transition, practitioners may assist patients to administer their medicines safely by preparing a form of medication card containing information transcribed from other sources.

21 For the long stay patient, whether in hospital or a nursing home, self-administration can help foster a feeling of independence and control in one aspect of life.

22 It is essential, however, that where self-administration is introduced for all or some patients, arrangements must be in place for the appropriate, safe and secure storage of the medicines, access to which is limited to the specific patient.

The use of monitored dosage systems

23 Monitored dosage systems, for the purpose of this paper, are systems which involve a community pharmacist, in response to the full prescription of medicines for a specific person, dispensing those medicines into a special container with sections for days of the week and times within those days and delivering the container, or supplying the medicines in a special container of blister packs, with appropriate additional information, to the nursing home, residential care home or domestic residence. The Council is aware of the development of such monitored dosage systems and accepts that, provided they are able to satisfy strict criteria established by the Royal Pharmaceutical Society of Great Britain and other official pharmaceutical organisations, that substances which react to each other are not supplied in this way and that they are suitable for the intended purpose as judged by the nursing profession, they have a valuable place in the administration of medicines.

24 While, to the present, their use has been primarily in registered nursing homes and some community or residential care homes, there seems no reason why, provided the systems can satisfy the standards referred to in paragraph 25, their use should not be extended.

25 In order to be acceptable for use in hospitals or registered nursing homes, the containers for the medicines must:

25.1 satisfy the requirements of the Royal Pharmaceutical Society of Great Britain for an original container;

25.2 be filled by a pharmacist and sealed by her or him or under her or his control and delivered complete to the user;

25.3 be accompanied by clear and comprehensive documentation which forms the medical practitioner's prescription;

25.4 bear the means of identifying tablets of similar appearance so that, should it be necessary to withhold one tablet (for example Digoxin), it can be identified from those in the container space for the particular time and day;

25.5 be able to be stored in a secure place and

25.6 make it apparent if the containers (be they blister packs or spaces within a container) have been tampered with between the closure and sealing by the pharmacist and the time of administration.

26 While the introduction of a monitored dosage system transfers to the pharmacist the responsibility for being satisfied that the container is filled and sealed correctly so as to comply with the prescription, it does not alter the fact that the practitioner administering the medicines must still consider the appropriateness of each medicine at the time administration falls due. It is not the case, therefore, that the use of a

monitored dosage system allows the administration of medicines to be undertaken by unqualified personnel.

27 It is not acceptable, in lieu of a pharmacist-filled monitored dosage system container, for a practitioner to transfer medicines from their original containers into an unsealed container for administration at a later stage by another person, whether or not that person is a registered practitioner. This is an unsafe practice which carries risks for both practitioner and patient. Similarly it is not acceptable to interfere with a sealed section at any time between its closure by the pharmacist and the scheduled time of administration.

The role of nurses, midwives and health visitors in community practice in the administration of medicines

28 Any practitioner who, whether as a planned intervention or incidentally, becomes involved in administering a medicine, or assisting with or overseeing such administration, must apply paragraphs 8 to 11 of this paper to the degree to which they are relevant.

29 Where a practitioner working in the community becomes involved in obtaining prescribed medicines for patients, she or he must recognise her or his responsibility for safe transit and correct delivery.

30 Community psychiatric nurses whose practice involves them in providing assistance to patients to reduce and eliminate their dependence on addictive drugs should ensure that they are aware of the potential value of short term prescriptions and

encourage their use where appropriate in the long term interests of their clients. They must not resort to holding or carrying prescribed controlled drugs to avoid their misuse by those clients.

31 Special arrangements and certain exemptions apply to occupational health nurses. These are described in Information Document 11 and the Appendices of 'A Guide to an Occupational Health Nursing Service; A Handbook for Employers and Nurses'; published by the Royal College of Nursing (4).

32 Some practitioners employed in the community, including in particular community nurses, practice nurses and health visitors, in order to enhance disease prevention, will receive requests to participate in vaccination and immunisation programmes. Normally these requests will be accompanied by specific named prescriptions or be covered by a protocol setting out the arrangements within which substances can be administered to certain categories of persons who meet the stated criteria. The facility provided by the 'Medicines Act 1968' (5) for substances to be administered to a number of people in response to an advance 'direction' is valuable in this respect. Where it has not been possible to anticipate the possible need for preventive treatment and there is no relevant protocol or advance direction, particularly in respect of patients about to travel abroad and requiring preventive treatment, a telephone conversation with a registered medical practitioner

will suffice as authorisation for a single administration. It is not, however, sufficient as a basis for supplying a quantity of medicines.

Midwives and Midwifery Practice

33 Midwives should refer to the current editions of both the Council's 'Midwives Rules' (6) and 'A Midwife's Code of Practice' (7), and specifically to the sections concerning administration of medicines. At the time of publication of this paper, 'Midwives Rules' sets out the practising midwife's responsibility in respect of the administration of medicines and other forms of pain relief. 'A Midwife's Code of Practice' refers to the authority provided by the 'Medicines Act 1968' and the 'Misuse of Drugs Act 1971'(8), and regulations made as a result, for midwives to obtain and administer certain substances.

What if the Council's standards in paragraphs 8 to 11 cannot be applied?

34 There are certain situations in which practitioners are involved in the administration of medicines where some of the criteria stated above either cannot be applied or, if applied, would introduce dangerous delay with consequent risk to patients. These will include occupational health settings in some industries, small hospitals with no resident medical staff and possibly some specialist units within larger hospitals and some community settings.

35 With the exception of the administration of substances for the purpose of vaccination or immunisation described in paragraph 32 above, in any situation in which a practitioner may be expected or required to administer 'prescription-only medicines' which have not been directly prescribed for a named patient by a registered medical practitioner who has examined the patient and made a diagnosis, it is essential that a clear local policy be determined and made known to all practitioners involved with prescribing and administration. This will make it possible for action to be taken in patients' interests while protecting practitioners from the risk of complaint which might otherwise jeopardise their position.

36 Therefore, where such a situation will, or may apply, a local policy should be agreed and documented which:

36.1 states the circumstances in which particular 'prescription-only medicines' may be administered in advance of examination by a doctor;

36.2 ensures the relevant knowledge and skill of those to be involved in administration;

36.3 describes the form, route and dosage range of the medicines so authorised and

36.4 wherever possible, satisfies the requirements of Section 58 of the 'Medicines Act 1968' as a 'direction'.

Substances for topical application

37 The standards set out in this paper apply, to the degree to which they are relevant, to substances used for wound dressing and other topical applications. Where a practitioner uses a substance or product which has not been prescribed, she or he must have considered the matter sufficiently to be able to justify its use in the particular circumstances.

The administration of homoeopathic or herbal substances

38 Homoeopathic and herbal medicines are subject to the licensing provisions of the 'Medicines Act 1968', although those on the market when that Act became operative (which means most of those now available) received product licenses without any evaluation of their efficacy, safety or quality. Practitioners should, therefore, make themselves generally aware of common substances used in their particular area of practice. It is necessary to respect the right of individuals to administer to themselves, or to request a practitioner to assist in the administration of substances in these categories. If, when faced with a patient or client whose desire to receive medicines of this kind appears to create potential difficulties, or if it is felt that the substances might either be an inappropriate response to the presenting symptoms or likely to negate or enhance the effect of prescribed medicines, the

practitioner, acting in the interests of the patient or client, should consider contacting the relevant registered medical practitioner, but must also be mindful of the need not to override the patient's rights.

Complementary and alternative therapies

39 Some registered nurses, midwives and health visitors, having first undertaken successfully a training in complementary or alternative therapy which involves the use of substances such as essential oils, apply their specialist knowledge and skill in their practice. It is essential that practice in these respects, as in all others, is based upon sound principles, available knowledge and skill. The importance of consent to the use of such treatment must be recognised. So, too, must the practitioner's personal accountability for her or his professional practice.

Practitioners assuming responsibility for care which includes medicines being administered which were previously checked by other practitioners

40 Paragraph 10.6 of this paper referred to the unacceptability of a practitioner administering a substance drawn into a syringe or container by another practitioner when the practitioner taking over responsibility for the patient was not present. An exception to this is an already established intravenous

infusion, the use of a syringe pump or some other kind of continuous or intermittent infusion or injection apparatus, where a valid prescription exists, a responsible practitioner has signed for the container of fluid and any additives being administered and the container is clearly and indelibly labelled. The label must clearly show the contents and be signed and dated. The same measures must apply equally to other means of administration of such substances through, for example, central venous, arterial or epidural lines. Strict discipline must be applied to the recording of any substances being administered by any of the methods referred to in this paragraph and to reporting procedures between staff as they change and transfer responsibility for care.

Management of errors or incidents in the administration of medicines

41 In a number of its Annual Reports, the Council has recorded its concern that practitioners who have made mistakes under pressure of work, and have been honest and open about those mistakes to their senior staff, appear often to have been made the subject of disciplinary action in a way which seems likely to discourage the reporting of incidents and therefore be to the potential detriment of patients and of standards.

42 When considering allegations of misconduct arising out of errors in the administration of medicines, the Council's Professional Conduct

Committee takes great care to distinguish between those cases where the error was the result of reckless practice and was concealed and those which resulted from serious pressure of work and where there was immediate, honest disclosure in the patient's interest. The Council recognises the prerogative of managers to take local disciplinary action where it is considered to be appropriate but urges that they also consider each incident in its particular context and similarly discriminate between the two categories described.

43 The Council's position is that all errors and incidents require a thorough and careful investigation which takes full account of the circumstances and context of the event and the position of the practitioner involved. Events of this kind call equally for sensitive management and a comprehensive assessment of all of the circumstances before a professional and managerial decision is reached on the appropriate way to proceed.

Future arrangements for prescribing by nurses

44 In March 1992 the Act of Parliament entitled the 'Medicinal Products: Prescription by Nurses etc Act 1992' (9) became law. This legislation is to come into operation in October 1993. The legislation will permit nurses with a district nursing or health visiting qualification to prescribe certain products from a Nurse Prescribers' Formulary. The statutory

rules, yet to be completed, will specify the categories of nurses who can prescribe under this limited legislation. The Council will issue further information concerning this important new legislation prior to it becoming operative.

45 Enquiries in respect of this Council paper should be directed to the:

Registrar and Chief Executive
United Kingdom Central Council
for Nursing, Midwifery and
Health Visiting
23 Portland Place
London W1N 3AF

References

1 United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 'Administration of Medicines; A UKCC Advisory Paper; A framework to assist individual professional judgement and the development of local policies and guidelines', April 1986.

2 United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 'The Administration of Medicines', PC 88/05, September 1988.

3 United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 'Code of Professional Conduct for the Nurse, Midwife and Health Visitor', Third Edition, June 1992.

4 Royal College of Nursing, 'A Guide to an Occupational Health Nursing Service; A Handbook for Employers and Nurses', Second Edition 1991.

5 'Medicines Act 1968', Her Majesty's Stationery Office, London, Reprinted 1986.

6 United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 'Midwives Rules', March 1991.

7 United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 'A Midwife's Code of Practice', March 1991.

8 'Misuse of Drugs Act 1971', Her Majesty's Stationery Office, London, Reprinted 1985.

9. 'Medicinal Products: Prescription by Nurses etc Act 1992,' Her Majesty's Stationery Office, London, 1992.