This article considers some current legal issues regarding nurse prescribing and non-medical prescribing highlighting some cases where prescribers have fallen foul of the law and the consequences of doing so. There is also a review of some of the most recent case law that impacts upon the delivery of safe, knowledgeable, care. These cases affect all types of prescribers and ignorance of these requirements is no defence in law.

The number of prescriptions dispensed in 2012 was 1.1 billion, which equals a total of 1,900 prescriptions per minute. 1.8% of this number (18 million) was originated by nurse prescribers and other non-medical prescribers, which showed a 10%, increase over 2011. (hscic 2013).

There were 232,708 registered doctors on the general Medical Council (GMC) register in 2016 of which 239 were refereed to fitness to practice panels (FtP) with 72 of these removed from the medical register.

Pharmacists, (51.980 registered pharmacists) of which 1,889 pharmacists were referred to the regulatory authority, the General Pharmaceutical Council, (GPhC) in the 2016/17 period. There was no overall number of de-registrations noted. Though several individual cases indicated issues with unsafe practice, poor recording of medicines received or dispensed including controlled drugs and incidents of misappropriation of pharmaceuticals including pharmacists or pharmacy technicians illegally supplying or selling drugs such as fentanyl for recreational use.

The Nursing and Midwifery Council (NMC) annual report 2016-17 states that there were 690,773 nurses and midwives on the register as of 31st March 2017. There were 5,476 reported concerns to the NMC leading to 1,513 hearings regarding nurses and midwives conduct.126 cases were concerned with prescribing and medicines management.

344 nurses were struck off the register following these hearings making a total of 23% of the cases referred.

In April 2017, registered nurse was running her own aesthetic and cosmetic business alongside her employment as a health visitor. The nurse had met a doctor on an aesthetics study course and he had signed a blank prescription form that she then filled in with Botox for injection. She then photocopied the prescription and submitted a further six copies which were dispensed by the local pharmacist at a total cost of £3,300 to the National Health Service (NHS).

Her behaviour was discovered when the pharmacist contacted the doctor with a query about one of the prescriptions that had been requested. The doctor was surprised to see he had been prescribing to people he did not recognise and the ruse was discovered. The nurse was prosecuted and received an 8 months prison sentence, suspended for 18 months, alongside an order for 200 hours community service. The Nursing and Midwifery Council decided that she should be struck from the NMC register indefinitely for "endangering patient's lives".

In another case, a consultant cardiac care nurse specialist nurse raised suspicions at her hospital when nursing staff became concerned about her erratic prescribing behaviours in the cardiac care unit. She claimed she had been awarded her nurse prescribing qualification at a university that had no record of her ever being registered with them as a student.

The reality was that she had attended two study days about prescribing medications and had no formal prescribing qualification at all. She was dismissed by her employers and reported to the NMC.

She was struck from the register indefinitely.

Notable cases including deciding the appropriate standard of care.

Under the current law of England and Wales, a patient can seek a remedy if the care given (or not given) is negligent and causes foreseeable harm. The legal remedy is via a process known as the "law of Tort" and is generally dealt with in the civil courts. Most cases are settled in the civil court and if found liable, financial damages may be awarded against the hcp, however, if cases of negligent

behaviour are so extreme and seen to be" criminally negligent," they can be tried in criminal court and attract a custodial sentence if it is decided the hcp is guilty of the offence.

In the case of FB v Princess Alexandria Hospital NHS Trust [2017] following a telephone call to an out of hours service, a 13 month old child was admitted to an emergency department (ED) of a hospital with a history of being unwell, having a pyrexia, erratic breathing and was rolling her eyes. It was the eye rolling that prompted the mother to seek medical advice. The child was admitted at 04:45 hrs, to the ED, seen by a triage nurse and then a Senior House Officer (SHO) at 05:20 hrs. The doctor gave a physical examination to the child and diagnosed an upper respiratory tract infection (URTI). The child was then discharged home at 05:55 hrs.

Over the next 12 hours, the child's condition worsened and she was re-admitted to hospital, seen by the paediatric team and given antibiotics. Some time later she was transferred to Great Ormond Street Hospital, where a diagnosis of pneumococcal meningitis with multiple brain infarcts was made resulting in permanent brain damage and deafness.

The crux of the case revolved around the contention that the SHO had not examined the child properly and had fallen below the reasonably expected standard of care, which then led to the child not being treated effectively and suffering brain damage as a result.

A key indicator of the child's poorly condition was the occurrence of uncoordinated eye rolling and accompanying lethargy (due to the high level of bacteraemia) that would indicate "abnormal state variation" (ASV) and appear more unwell than if they simply had a URTI.

The SHO had failed to ask the parents why they had brought the child into hospital in the first instance. It is generally accepted that most healthcare professionals consider that the child's parents know the child much better than anyone else and so signs of unusual behaviour in the child are usually identified by the parents first and these indicators should be taken seriously by the hcp examining the child.

It was argued in court that this type of inquiry about the child's condition was a failure of basic history taking and fell below the reasonable standard of care that a competent SHO would be expected to give. So in the FB case, the doctor should be judged by the standard of a reasonably competent SHO in an ED. If a proper history and assessment had been completed this may have reduced the risk that eventuated. It was then argued that history taking is a basic skill at which doctors at all levels are expected to possess.

The importance of this case is that it sets the standard by which non-medical prescribers will be judged by in cases that come before the courts. Healthcare practitioners must display the ability to deliver safe, competent care and when they fail to show these skills they run the risk of not meeting the expected standard of care and may become liable in tort for damages.

The reasonable standard of care expected by a junior doctor was considered in the case of Wilsher v Essex AHA [1987] where it was held that the level should be that of the post or position the doctor was covering for. Hence, if a junior was acting up to the level of a consultant for example, that the standard by which they are judged should be that of a consultant in that post not the junior level.

This was reinforced in the case of Nettleship v Weston [1971] where an inexperienced driver, involved in an accident, claimed because she was a learner driver, she shouldn't be judged by the same standard as a qualified driver, rather, that a lower standard should apply.

The case was settled against her with the precedent being set that the same standard of care applied to inexperienced as to experienced drivers. The application of this finding in non-medical prescribing is that an inexperienced prescriber cannot claim that the standard of care they deliver can be of a lower standard than a more experienced prescriber, simply because they are learning how to prescribe medications.

Patient autonomy, consent and information sharing.

The law regarding patient consent and a patient's right to autonomy was considered in Montgomery v Lanarkshire Health Board [2015]. Mrs Montgomery was expecting her first child and was under the care of an obstetric consultant. Mrs Montgomery was an insulin dependent diabetic that had a small pelvis. These factors combined to increase the risk of a difficult delivery as babies from diabetic mothers can have more weight distributed around their shoulder area, which can cause the shoulder to wedge in the pelvis at delivery causing shoulder dystocia and oxygen deprivation. The risk is estimated around 9-10%. The consultant did not discuss this situation at all with Mrs Montgomery because she felt the risk was very small and as she stated in her defence, "if she was to say to every diabetic mother, that there was a small chance of the baby dying in labour, everyone would ask for a caesarean section, and it's not in the maternal interests to have a caesarean section" [13]

This baby's delivery was difficult and between his head appearing and delivery his shoulder became impacted in the pelvis for around 12 minutes, occluding the umbilical cord depriving him of Oxygen and as a result, he was born with severe disabilities. The case was decided in Mrs Montgomery's favour and the consultant was found liable for damages (£5.2 million).

The importance of this decision is the courts recognise that patients have the right to make choices about their treatment, the risks involved and the availability of other treatment options (including refusal of treatment) and that paternalistic attitudes, whereby healthcare professionals make decisions for the patient are no longer acceptable. In a nutshell, it's the healthcare professionals' duty to inform and advise and the patient's right to decide. Obviously, with prescribed medications it means that the rationale for their use should be explained and any side effects or other variant treatments should be offered, as this is all part of good medicines management and therapeutic patient care.

In conclusion, it is always important for all prescribers to be aware of one's limitations when assuming roles and responsibilities in the course of one's work, as competence will be measured against the reasonable expectations of that job role. The law of the land and the expectation of

professional bodies is that registrants will provide safe, knowledgeable, competent care to patients who expect appropriate advice that enables them to decide the treatment that is best for them. Standards of professional behaviour have to be maintained in and outside the work setting and if these are found to be inappropriate, professional bodies will investigate allegations of illegal or disreputable behaviours and if these are found to be proven the consequences can be severe leading to loss of registration and loss of career.

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