journey to change

NHS
Tees, Esk and Wear Valleys
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Medicines - Prescribing and Initiation of Treatment

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Contents

1 Purpose

Following this procedure will help the Trust to:

- Provide personalised care through the effective prescribing of medicines
- Prescribe medicines safely
- Comply with legal and professional requirements in the authorised supply of medicines

This procedure supports Our Journey to Change as set out in the Medicines Overarching Framework.

2 Related documents

This procedure describes what you need to do to implement the Prescribing and Initiation of Treatment section of the Medicines Overarching Framework.

The Medicines Overarching Framework defines compliance requirements for prescribing and initiating treatment safely which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:

- ✓ Medicines reconciliation procedure
- ✓ NMP Policy and Procedure to Practice
- ✓ NMP Procedure to access training
- ✓ Oxygen and other medical gases – administration, prescribing, storage, safety
- ✓ New drugs – application process for TEWV
- ✓ Guidelines for use of Unlicensed and Off-Label Use of Medicines
- ✓ Diabetes Management
- ✓ Safe Lithium Therapy and Shared Care Guidelines
- ✓ Standards for use of 'as required' medication
- ✓ Patients Own Drugs procedure
- ✓ Medication Safety Series
- ✓ PGD Overarching Framework
- ✓ Controlled Drugs Standard Operating Procedures
- ✓ Rapid Tranquillisation Policy
- ✓ Safe Transfer of Prescribing guidance
- ✓ FP10 Prescription Management

3 Starting treatment

A competency framework for all prescribers is available nationally to support prescribers and sets out what good prescribing looks like. The framework is generic for prescribers of all professional background and in any setting. The following list is more specific to a mental health setting but should not be considered comprehensive as each patient needs to be considered individually. It is intended to describe some key aspects which need to be considered before initiating / changing medication:

- The principles of shared decision making and informed patient choice
- Provision of appropriate information for the patient, family and carers
- The indication being treated and associated evidence
- Formulary status of the medication
    - Is an application required before initiating?
- Current guidelines for the indication (trust guidelines or NICE / other guidelines where available)
- Consent to examination or treatment policy
- Consideration of the benefits vs. risks and a rationale for the choice
    - **Risks may include, but are not limited to:**
        - Age
        - Other health conditions
        - Side effects / adverse events
        - Contra-indications
        - Cautions
        - Other medications including illicit, complementary and over the counter
        - Drug & other interactions
        - Smoking, alcohol, caffeine intake
        - Pregnancy or breast feeding
        - Hepatic or renal impairment
        - Substance misuse
        - Overdose
        - Fraud
- Rationale and consent when prescribing off-label / unlicensed medicines
- Medicines adherence
- Polypharmacy (over-prescribing / STOMP)
- Planned duration of treatment

- Process of titrating (and cross-titration) / reducing / stopping medication (deprescribing)
- Drug, dose, formulation, dosing instructions (including any special requirements)
- Deprescribing of existing medication
- Expected impact on mental and physical health
- Required monitoring / planned review:
- Physical health monitoring
- Well-being
- Mental health
- Impact / effect of medication
- Process of transfer of prescribing (if applicable)

After assessment, a patient's pharmacological treatment is initiated:

- With a patient specific prescription by a registered prescriber
- Under a Patient Group Direction which has been approved by the Drug and Therapeutics Committee
- Under a specific protocol which has been approved by the Drug and Therapeutics Committee

4 Prescribing medicines

The detailed guidance on prescribing contained in the current edition of the British National Formulary (BNF) must be followed.

Prior to initiation of a new medicine, check the BNF or relevant product information for any **cautions** or **contra-indications** to the chosen treatment.

Prescribers must prescribe within their own competencies, and comply with the current legislation, Trust policies for prescribing and professional guidance.

4.1 What is a prescription?

A prescription is a written order for the supply or administration of a medicinal product to an individual who is a patient of the Trust. This procedure covers prescriptions written on:

- the inpatient prescription and administration chart
- the home based treatment chart (used in York only)
- leave and discharge prescription forms (handwritten and electronic)
- outpatient prescriptions forms
- FP10 prescriptions forms

4.2 Who can write a prescription?

✓	A registered medical practitioner, dentist, independent or supplementary non-medical prescriber or health visitor. Non-medical prescribers must have their prescribing status annotated on their professional register and must be authorised to prescribe within the Trust.
✓	Non-trust staff can prescribe treatments on the prescription and administration record where patients have attended A&E, out of hours primary care services or outpatient clinics and will be returning to the Trust ward to receive the prescribed treatment
~	Dietitians may write up food for special diets, enteral sip or tube feeds, feed supplements and feed additives for inpatients on the prescription and administration chart. In doing so, they can add the demographic and allergy information, if this entails writing on a new chart. Note: this is not prescribing
~	Creams and other wound care products that are not prescription only can be added to Tissue Viability plans by a registered nurse. Note: this is not prescribing
×	Medical students and physician associates cannot prescribe or transcribe medication.
×	F1 doctors cannot prescribe on a FP10.
×	Prescribers cannot write Trust prescriptions for themselves or their family or other members of hospital staff unless the member of staff is also a patient of the Trust under the care of the prescriber.

4.3 Prescribing restrictions

Some medications are subject to prescribing restrictions in the Trust e.g. controlled drugs, unlicensed medicines (See relevant sections in the Medicines Overarching Framework).

4.4 Allergies and sensitivities

The prescriber must take account of the patient's allergy status and medicine intolerances when prescribing any medicines.

Information on known allergies/sensitivities must always be recorded on the patient's clinical records including all prescription and administration records (if applicable) by the prescriber, pharmacist or nurse as appropriate.

Where there are no known sensitivities, the "No known drug allergies" box should be ticked on all prescription and administration records and the prescriber should sign and date accordingly.

4.5 Reconciling medicines on admission

Medicines prescribed on admission should be reconciled against the checks made on current medication with the patient, GP, carer and against medicines brought in by the patient and record accordingly. See Medicines reconciliation procedure

4.6 Discharge of inpatients

When an inpatient is discharged prompt communication to the GP should include a comprehensive list of the medicines the patient is receiving together with any changes to treatment made during the admission and clear guidance on what medicines the GP is expected to continue with any monitoring requirements. Details of any allergies or adverse drug reactions experienced during admission should also be included.

4.7 Community patients

The care of community patients may be shared by a Trust doctor and the general practitioner (GP). When a Trust prescriber initiates a change in treatment they are responsible for promptly informing the patient's GP of details of any change together with a comprehensive list of medicines the patient is currently prescribed.

4.8 Prescribing queries

Queries relating to a potentially serious error or risk must be alerted to the prescriber immediately by the health professional.

Make a record of the conversation with the prescriber in the patient's electronic record and complete a record of the incident on Datix. Communication notes left for the prescriber are not acceptable in situations where the patient could be exposed to significant risk.

Pharmacists, nurses or other health professionals who wish to query or comment on a patient's prescription must contact the prescriber using an appropriate method to bring the query to the attention of the prescriber in a timely manner. Details of clinically significant interventions must be recorded in the patient's electronic record and the prescriber notified of the entry.
See Appendix 1 for Position Statement on Nurses giving prescribing advice to GPs, Acute Trust prescribers and Non-Medical prescribers

5 Non-medical prescribing

- ✓ NMP Policy and Procedure to Practice
- ✓ NMP Procedure to access training

6 Patient Group Directions (PGDs)

The use of Patient Group Directions in the Trust is covered in a separate PGD overarching framework.

7 Protocols

A protocol is a written direction to administer a General Sales List Medicine (GSL) without a patient specific prescription. The medicines that can be administered, their indication, dose, frequency and age range are specified within the protocol. Oxygen may be administered by any staff that has undertaken First Response Training. Oxygen and other medical gases – administration, prescribing, storage, safety

8 Verbal orders to supply a medicine

A pharmacist, in order to support the dispensing process, may receive a verbal order from a prescriber to alter or add a prescription item on a leave, discharge or out-patient prescription. The pharmacist must read the alteration or addition back to the prescriber who must then confirm it. Verbal orders cannot be given for controlled drugs, except for minor amendments (see Controlled Drugs Standard Operating Procedures).

9 Verbal orders to administer a medicine

Verbal orders are only acceptable to enable the administration of a medicine in a medical emergency. In some medical emergencies a prescription is not required – both adrenaline for anaphylaxis (MSS9) and emergency oxygen (MSS10) can be given without a prescription (click links to medication safety series documents). An example of an appropriate verbal order would be to administer aspirin as per the chest pain protocol.

If it is not a medical emergency, but remote prescribing is required, refer to section 10.

10 Remote orders to supply or administer a medicine

Before prescribing for a patient remotely, the prescriber must satisfy themselves that they can make an adequate assessment, establish a dialogue and obtain the patient's consent (where necessary). The prescriber may only prescribe when they have adequate knowledge of the patient's health and are satisfied that the medicines serve the patient's needs. The prescriber must consider:

- the limitations of the medium through which they are communicating with the patient / staff member
- the need for physical examination or other assessments
- whether they have access to the patient's medical records.

Note that only a medical prescriber can remotely prescribe a new medication.

A pharmacist can accept a remote order from a prescriber but this must be followed up with a signed prescription within 24 working hours*. The type of remote order appropriate to the pharmacy will be defined by the specific pharmacy and / or specific SOPs. This may take the form of an email.

In appropriate circumstances a remote order may be accepted by a registered nurse to administer a previously prescribed medication, or in exceptional circumstances a new medication. The prescriber must take a thorough history from the nurse and, if possible, speak to the patient before

making the decision to prescribe. The prescriber must check the electronic patient record for the allergy status and if section 58 of the Mental Health Act applies. An email prescription may be accepted by the registered nurse. The email must be supported by an electronic patient record entry, made by the prescriber, detailing:

- Reason for being unable to attend in person to assess service user
- The allergy status and Mental Health Act status and if section 58 applies
- Medication name, dose and frequency (also duration if appropriate)
- Indication or target symptoms of service user
- Discussion with service user or reason why not possible
- If any pre- or post-administration monitoring us required by ward staff
- When and how service user should be reviewed due to medication change

Details must be entered in the relevant section of the prescription and administration record, if another nurse is available in that location the transcription should be double checked. The electronic patient record entry and the email should be kept with the prescription and administration record until the prescriber has signed the entry, it should then be filed in the patient's notes. The entry must be signed by the prescriber within 24 working hours*.

*Working = 9am-5pm weekdays

11 Range of medicines which can be prescribed

All patients of TEWV will be prescribed the medicines they require based on assessment of their symptoms and their clinical need. To ensure the best use of limited resources the Drug and Therapeutics Committee has adopted a formal and structured procedure for the introduction of new drugs. New drugs – application process for TEWV

Only medicines approved for use by the Drugs and Therapeutics Committee can be routinely prescribed to treat mental health conditions. These are listed in Chapter 4 on the Formulary website for the locality: County Durham & Tees Valley or York & Scarborough.

For non-psychiatric medication prescribers are advised to continue existing treatments and only initiate new medicines in line with the above formularies.

Application to prescribe a medicine identified as 'Restricted formulary' or 'Named Patient only' by the Drug and Therapeutics Committee must be made by the consultant using the Single application form and sent to the appropriate Clinical Director for approval. Pharmacy will only authorise supply on receipt of approval from the Clinical Director.

For non-approved medicines: an application can be made by the consultant using the Single application form if exceptional circumstances can be demonstrated. The application will be considered by a panel.

The Drug and Therapeutics committee will monitor applications to prescribe restricted, named patient and non-formulary medicines.

12 Prescribing unlicensed and 'off-label' medicines (outside of licensed indications)

See Guidelines for use of Unlicensed and Off-Label Use of Medicines - these guidelines seek to minimise the risks to patients and clarify the legal liability of healthcare professionals.

A medicine with a valid UK marketing authority for the proposed indication should be prescribed whenever possible. Prescribers should be aware of the licensed status of the medicines they prescribe and pharmacists should advise prescribers of any changes to such status.

Medicines may sometimes be prescribed for an unlicensed indication, or at a dose, via a route or for an age that is outside the range specified in the Summary of Product Characteristics for that medicine – so-called "off-label" prescribing.

Unlicensed medicines are medicines that do not have a marketing authorisation in the UK. They are medicines that have either been specially prepared by the holder of a Manufacturers Specials Licence to meet the special needs of individual patients (often called "specials") or imported.

Prescribers should carefully consider the use of medicines "off-label" or unlicensed medicines and only use this form of therapy when the benefits outweigh the risks and where there is no licensed alternative available.

Prescribers must obtain consent to treatment and inform the patient of the medicine's licence status. The patient must also be informed that the effects of an unlicensed medicine will be less well understood than those of a licensed medicine. A patient information leaflet on the use of unlicensed medicines should be provided before obtaining consent to treatment

Prescribers should inform their medical colleagues (especially General Practitioners) of the medicine's licence status when advising them to use unlicensed medicines or medicines outside of their marketing authorisation (off-label use).

The pharmacy supplying unlicensed medicines will take the necessary steps to ensure their quality.

13 High risk medicines

A number of medicines have been identified through the National Reporting and Learning Service, and locally, as being high risk in terms of the potential harms associated with their use. Critical medicines have been identified as those medicines which may cause harm if their administration is omitted or delayed. Some medicines are both high risk and critical.

High risk medicines:

- Opioids
- Methotrexate
- Oral chemotherapy & cytotoxics
- HDAT (high-dose antipsychotics)
- Anticoagulants
- Clozapine
- Insulin
- Lithium

13.1 Critical Medicines - reducing harm from omitted and delayed medicines in hospital

Doses of medicines are occasionally omitted or delayed in hospital for a variety of reasons. Whilst these events may not seem serious, for some critical medicines or conditions, such as patients on lithium or with pulmonary embolism or diabetes, delays or omissions can cause serious harm, poor outcomes or even death.

Nursing staff must **not** omit these medicines but must **contact** medical staff for further advice, including out of hours, if administration is not possible for any reason.

If the route of administration is not possible it will be necessary to review formulations and routes.

If the drug is not available within a reasonable time (90 minutes) it will be necessary to consider an alternative formulation (e.g. liquid preparation instead of solid dosage form) or alternative drug.

The trust pharmacy team or the on call pharmacist is always available for advice.

- Consider whether it is necessary to prescribe a once-only dose if the administration time window has been missed.
- **Tell** the nursing staff when a once-only dose is prescribed.
- Significant delays or omissions of any of the critical medicines must be reported as a medication incident via Datix.
- A full list of critical medicines and more information and advice can be found in MSS 17 Critical Medicines.

13.2 Anticoagulants

Warfarin is a high risk drug due to the high level of intra patient variability, and numerous drug and disease interactions. Most patients will have a copy of the “Yellow book” patient held record which details their recent INR monitoring and warfarin doses. Additional copies are available from pharmacy. See Medication Safety Series 5 Warfarin for guidance.

The direct oral anticoagulants (**DOACs**), Dabigatran, Rivaroxaban, Edoxaban and Apixaban are also available though they do not require the same monitoring as the coumarins (warfarin, acenocoumarol and phenindione) - it must be noted that the main adverse effect is haemorrhage. See Medication Safety Series 11 DOACs for guidance.

Treatment doses of Low molecular weight heparins have weight based dosing for each condition whereas prophylactic doses are more standardised and sometimes adjusted for renal function. It is important to weigh the patient to calculate the dose or ask the carer for a recent weight rather than Trust staff estimating weight. It is also important to monitor renal function as eGFR below 30ml/min may require a dose reduction or additional monitoring of anti Xa (speak to the haematologists). This should not delay the initial dose.

A medication alert should be added to the electronic record of any patient receiving an anticoagulant.

13.3 Insulin – see Medication Safety Series 6 for guidance

Insulin doses must not be omitted as this complicates management and may lead to diabetic ketoacidosis or hyperglycaemia hyperosmolar state.

If the prescriber is unable to determine or is unsure of a patient's insulin dose the diabetologists at the local acute Trust are always available for advice. More detailed guidance on insulin dependent diabetes is available on in the Diabetes Management guidelines.

Most patients should have an insulin passport which details the type of insulin and the device.

Beware as some long acting and short acting insulins have similar names for example Novo rapid and Novo mix, or Humalog and Humalog 50 and there are now two strengths of insulin glargine available Lantus®/Abasaglar®/Semglee® 100 units/ml and Toujeo® 300 units/ml.

- When prescribing **never** use U or IU, always use **units.** If prescribed as either U or IU the nurses must **not** give but contact the prescriber to have the prescription and administration chart amended.
- Insulin doses must be measured and administered using an insulin syringe or a commercial insulin pen device. Ordinary syringes must **never** be used for measuring or administering insulin.

13.4 Opioids - reducing harm from strong opioid prescribing

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient as well as the **time** and **date** of any changes. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber, through medication records (including summary care record) or contacting their regular community pharmacy.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not **normally** more than 50% higher than the previous dose).
- Ensure you are familiar with the following characteristics of that medicine and formulation: **usual starting dose**, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.
- Ensure the formulation is appropriate for the intended frequency. For example MXL® (morphine 24 hourly modified release preparation) is prescribed once a day, MST® or Zomorph® are prescribed twice a day, whereas Oramorph® should be prescribed four hourly. Similarly Oxy**Contin**® is prescribed twice a day where Oxy**Norm**® is prescribed four hourly.

13.5 Buccal midazolam

Buccal midazolam can be used in varying doses to treat status epilepticus in adults and children. It is administered to the buccal mucosa (between the gum and cheek). It is available in two strengths; a 5 mg/mL oral liquid product, recently licensed for paediatric use (Buccolam®) in a range of prefilled oral syringes, and an unlicensed 10 mg/mL oral liquid product (Epistatus®) is available from various 'specials' manufacturers in a multi-dose bottle and / or prefilled oral syringes.

- Always check which brand the patient has been using and counsel them carefully if there are changes to the brand they are supplied with
- Ensure that the dose is always prescribed in mg.
- Check the strength of solution prior to administration.
- Where appropriate give the Buccal midazolam (Buccolam) - carer information sheet

13.6 Clozapine – see Medication Safety Series 4

Clozapine is evidence based treatment for treatment resistant schizophrenia and can only be initiated by consultant psychiatrists. There is a risk of agranulocytosis particularly during the first year of treatment and so it is mandatory for patients starting on clozapine to be registered with the relevant clozapine monitoring service (e.g. CPMS for Clozaril®). Initially the dose is slowly titrated with physical health and side effect monitoring as well as the mandatory weekly full blood counts (FBCs).

Timing of clozapine dosing is important to maintain control of the patient's symptoms and aid recovery. If Clozapine is omitted for 48 hours or more **this necessitates the complete re-titration from the starting dose of 12.5mg.** Sometimes the consultant will decide to re-titrate more rapidly depending upon the patient's response and tolerability during first initiation.

Clozapine needs careful and mandatory monitoring with regular FBCs and other physical health checks

Dose changes should be only be made with input from senior medical staff.

If in doubt, speak with a Trust pharmacist.

Side effects to be aware of are

Tachycardia. Common, not concerning in the absence of chest pain. If pain is present, troponin T and ECGs should be checked, and if concerns persist, cardiology opinion should be sought.

Myocarditis and cardiomyopathy. Most cases of myocarditis occur within the first 4 weeks and present with classic symptoms of fever, palpitations, fatigue (also seen in patients who do not have myocarditis), chest pain, dyspnoea and decreased exercise capacity or may be symptomless. During the first month weekly FBC, Troponin I or T, CRP and ECGs monitor for myocarditis but will not detect all cases so vigilance is needed. Cardiomyopathy occurs late in treatment but presents with dyspnoea and reduced exercise tolerance.

Agranulocytosis (dangerously low WCC or downward trend). Regular FBCs are needed via the CPMS schedules.

Constipation and clozapine–induced hypomotility (CIGH) is common and may rarely but significantly lead to bowel obstruction leading to distension, necrosis, perforation or sepsis, aspiration from faecal vomiting and faecal stasis leading to infection. In uncomplicated cases bulk forming laxatives such as ispaghula husk are appropriate. In cases of sudden onset and deteriorating physical health, expert advice should be immediately sought and potent stimulant or osmotic laxatives should be started. Enemas are effective in cases of impaction or unresponsive constipation.

13.7 Lithium

See Safe Lithium Therapy and Shared Care Guidelines and Medication Safety Series 2

- Lithium is a high risk medicine due to its narrow therapeutic index - some patients have been harmed because they have not had their dose adjusted based on regular blood tests.
- Delays and omissions of Lithium doses will falsely influence the monitoring of Lithium levels as blood sampling should be carried out 12 hours post dose.
    - Clinically significant alterations in lithium blood levels occur with commonly prescribed and over-the counter medicines including ACE inhibitors and **NSAIDS** e.g. ibuprofen and naproxen. (see SBARD)
        - Pharmacists will provide advice on interactions if required.
- Declining renal function may also increase the risk of toxicity which is why it is important to monitor it alongside thyroid function.
- Most patients on Lithium therapy will carry a "purple book" patient hand held record detailing the dose of lithium and recent blood tests.
    - Additional copies of the hand held record are available from pharmacy.

13.8 Cytotoxic agents

13.8.1 Methotrexate – see Medication Safety Series 3 (DMARDs)

For non-cancer indications, such as rheumatoid arthritis, methotrexate is always prescribed as a **once weekly** dose as a steroid sparing agent. Inappropriate prescribing or administration of daily methotrexate is a "never event".

- It is the prescriber's responsibility to record the correct dosage and frequency on the prescription and administration chart, and to strike out the six days of the week when a dose must not be administered.
- Be aware of patients who attend with symptoms such as breathlessness, dry persistent, cough, vomiting or diarrhoea, as these can be signs of oral methotrexate toxicity or intolerance.
- Most patients will carry a hand held record detailing their dose and monitoring. Additional copies of the hand held record are available from pharmacy.

13.8.2 Oral Chemotherapy

Recently many more chemotherapy regimens are oral rather than IV which increases the possibility of a patient being admitted on an oral chemotherapy regimen.

- These patients **must** be referred to the oncologist or haematologist for advice and confirmation of their regimen. A copy of the patient's treatment plan must be sent from the acute Trust to confirm the patient's chemotherapy regimen and included in the medicines reconciliation.

14 Standard procedure for prescribing

14.1 General principles

Medicines may only by prescribed on official national (i.e. FP10s) or TEWV prescription stationery which is subject to regulated distribution around the Trust. The use of new documentation relating to prescribing of medicines must be approved by the Chief Pharmacist before its introduction.

- Prescriptions must be clearly written in **block letters**, typed or computer generated in indelible black ink.
- The prescription must clearly identify the patient for whom it is intended. In most settings this will include name, address, date of birth and NHS number. Name and address labels should not be used on FP10 prescription forms.
- The drug name should not be abbreviated. The British National Formulary (BNF) approved name should be used unless there is a specific exception such as a compound preparation that is usually recognised by brand name (e.g. oral contraceptives) or a brand name is required due to the differences in bioavailability between products (e.g. lithium - should always be prescribed as Priadel®, Camcolit® etc.) and modified-release preparations
- Doses must be stated in SI units using only accepted abbreviations i.e. mg, ml, g. The terms microgram, nanogram and unit must not be abbreviated.
- DO NOT use “mls” to indicate the dose of liquid preparations.
- Roman numerals e.g. ii, are a cause of medication errors and must not be used.
- Quantities / strengths of less than 1 g must be expressed in mg e.g. 100 mg not 0.1 g. Quantities of less than 1 mg must be expressed as micrograms e.g. 100 micrograms not 0.1 mg. A zero should be written in front of a decimal point where there is no other figure e.g. 0.5 ml not .5ml.
- The frequency must be written in full and ideally in English - Latin abbreviations such as BD, TDS should be avoided.
- Dose titrations should follow the standard licensed dose titration. Any deviation from the licensed titration must be recorded clearly with the rationale stated in the electronic care record.
    - When writing a prescription for a dose titration, the instructions must be clear indicating exactly when each change in dose is to be made.
- Where a prescription has been written for supply (rather than administration) then total quantity required must be clearly stated.
- All prescriptions must be dated and signed by the prescriber.

A record of medicines prescribed, stopped or changed must be recorded on the electronic patient record.

The standard for recording information about medicines on the electronic patient record and in any communication with GPs should follow the general principles for prescribing described above. As a minimum the following should be clearly described in the electronic care record for newly initiated medication.

- **Details of the medication prescribed** (including drug, indication, form, dose and quantity)
- **Rationale for the decision** (include key factors in decisions making – see section 3)
- **Patient information provided** (describe level of shared decision making and note information provided – to patient / family / carer – including any significant discussion points)
- **Treatment plan** (as appropriate describe plans for review, monitoring of effectiveness, physical health monitoring, next steps)

It is recommended that this information is recorded as a "Medication Treatment Plan" case note. See appendix 3 for recording advice.

15 Prescription and administration record

The prescription and administration record, or equivalent, must be available to the prescriber or healthcare practitioner whenever s/he is reviewing the patient.

Where more than one chart is used all charts must indicate the existence of other additional charts e.g. "chart 1 of 2"

When a patient is re-admitted, including for respite care, a new prescription and administration record must be used. Any deviation to this requirement must be approved as a local protocol by the Chief Pharmacist.

The prescription and administration record of patients transferred from one Trust site to another does not need to be rewritten but the ward/site/consultant information should be updated. When patients are transferred from other Trusts, a new drug prescription and administration record must be written.

Non-TEWV staff can prescribe treatments on the prescription and administration record where patients have attended A&E, out of hour's primary care services or outpatient clinics and will be returning to the TEWV ward to receive the prescribed treatment. Conversely, TEWV prescribers may be required to prescribe on a non-TEWV chart, e.g. Liaison services while patient is in acute hospital setting, if permitted by the Trust in which the patient is being treated.

Medicines for the palliative end-of-life care of a patient on a TEWV ward may be prescribed on a palliative medication charts from other organisation where this would be safer and more appropriate than prescribing on the TEWV prescription chart.

In addition to the main prescription chart there may be other supplementary prescribing and/or monitoring charts in use e.g. clozapine titration, insulin, high dose antipsychotics. The main prescription chart must make reference to such charts in the "other charts in use" box on the front page. These additional charts must be kept with the main chart at all times. For prescribing charts,

the relevant medicine must be prescribed on the main record, with reference to the supplementary chart in the instructions, e.g. “see supplementary chart”.

15.1 Writing a prescription on the prescription and administration record

Guidance on completing the inpatient prescription and administration chart is here.

Standards for prescription writing can be found on the back page of the TEWV prescription and administration record and in Appendix 2 (Standards for Rewriting Prescription Charts). A well written prescription chart enables the rapid and accurate interpretation of the medicines required by the patient. All prescriptions must be written in black ink and any interventions made by a pharmacist or pharmacy technician must be added in green or purple ink.

Details that should be included on the top of the inside back page (which is visible at all times) when writing a new prescription and administration chart:

- Patient name
- Date of birth
- NHS number
- Electronic care record number
- Known allergies/sensitivities/intolerances – complete and sign the relevant boxes
- Date of admission to the current ward
- Current ward, site and consultant

Details that should be included on the front of the chart include:

- Consent and capacity information
- Other prescription and monitoring charts in use
- Date card started/rewritten
- Smoking status – on admission or at re-write
- Current nicotine replacement (if relevant)
- Weight – on admission or at re-write
- VTE risk assessment – in line with Trust policy; on admission or at re-write

Each prescription must include the following information:

- **Name and form of the medicine:** The BNF approved name of the medicine must be written clearly in **block letters** (see general principles). The form of a medicine must be specified; solid dose is understood unless otherwise stated.
- **Dose and quantity**: see general principles. Doses must be specific, variable doses must not be used with the exception of Glyceryl Trinitrate (GTN) spray where a dose of one or two sprays is permitted

- **Route of administration:** The route must be specified. Only approved abbreviations should be used e.g. IM for intramuscular, SC for subcutaneous, Neb for nebulised, subling for sublingual, PR for rectal, PO for oral, PV for vaginal. Location or area of application for topical medicines must be specified. A separate line on the chart must be written for different routes of administration of the same drug. There should be no evidence of striking out or alteration of the route.
- **Start Date:** Indicates the date the treatment commences or the date of admission. This start date must be carried forward to any rewritten prescription sheets in the future.
- **Start Code:** Should be selected and completed by the prescriber from the list on the back of the chart.
- **Times of administration:** The times of administration must be ticked if to be given at usual mealtimes/bedtime or specified by the prescriber in the appropriate column on drug prescription and administration record. To avoid confusion do not indicate times in both columns. When entering times the 24 hour clock must be used. If the frequency is more than once daily, doses should be spread as evenly as possible over the day. (Additional blank rows are available where the time must be specified to allow for prescription of regular medicines more than four times a day)
- **Comments:** Any additional information regarding the prescribed medicine can be recorded in the "comments" section for that particular medicine for both regular and "as required" prescriptions.
- **Signature of prescriber:** Each prescription item must be validated by the full signature of a prescriber. Prescriber's initials or abbreviated signatures are not an adequate means of identification or authorisation. The prescribers name must be printed below the signature.
- **Changes to dose or frequency or formulation or route**

  A change of dose or frequency of administration or formulation or route is regarded as a new prescription and must be written as a new prescription and not by alteration to existing instructions.
- **Cancellation of treatment:** A bold vertical then diagonal line through the remaining administration record from the date and dose of discontinuation should be used to indicate a medicine has been stopped. The cancellation must also be initialled and dated in the "stop date" box. When the 'stop date' box is used in anticipation of the treatment cancellation date e.g. for courses of antibiotics, this indicates that at 23.59 on the date specified the prescription must be discontinued and no further doses administered. Prescribers should also enter the stop code indicating why the medication was stopped.

  When a chart is full a diagonal line should be drawn across the front and the word cancelled written and signed and dated by the prescriber.
- **Allergies/sensitivities: Unless it is an emergency confirmation of allergy status must be documented on the prescription and administration record prior to prescribing.** If no known allergies the appropriate box must be ticked and signed. The "unable to confirm" box can only be used out of hours to enable medication prescribed prior to admission to be administered, as soon as practically possible, the allergy status should be confirmed and

the appropriate section of the allergy box completed and the "unable to confirm section" crossed through.

- **Once only doses:** Medicines that are intended to be given once only, including rapid tranquilisation (see below), must be prescribed in the 'once only' section of the prescription chart.
- **As required medication (PRN):** The prescriber must state the maximum dose intended in a 24 hour period (taking into consideration doses prescribed as regular medication) and also the minimum dose interval and indication e.g. four hourly for nausea. The minimum dose interval must be expressed in hours (or minutes for some forms of NRT), "QDS", for example, is not acceptable; however, "once per night" is acceptable for night sedation only. Separate prescriptions must be written for different routes of administration of the same medicine.

  Prescribing a medicine on an 'as required' basis provides a useful method of assessing the person's requirements for medicines such as anticholinergics and analgesics. These medicines should be reviewed every 14 doses and the review box signed by a prescriber if the medicine is to continue, medication can continue to be given if this box is not signed, but a review and signature must be requested as soon as practicable.

  Medicines originally prescribed 'as required', but which are needed regularly as indicated by the administration record, must be reviewed and rewritten in the regular prescription section with the exception of hypnotics and benzodiazepines.

  When the prescription chart is rewritten the need for PRN medication should be reviewed.

  When separate PRN charts are used these must be reviewed and rewritten at least annually.

  Further information is provided in the Standards for use of 'as required' medication Standards for use of 'as required' medication document which includes guidance on as required doses by specialty.

15.2 Rapid tranquillisation – see RT policy

DO NOT prescribe medication for RT routinely on admission, in anticipation of an event. If an event is highly likely (e.g. admissions to PICU), a single dose may be prescribed in the "once only" section of the inpatient chart to allow nurses to manage the event initially in the absence of a doctor. A doctor MUST attend before a second dose is administered and if it is required, this must also be prescribed in the "once only" section.

RT may be prescribed "as required" for individual patients who have undergone a thorough psychiatric assessment prior to admission which has identified a high risk of disturbed behaviour likely to require restraint and intervention, for example:

- acutely unwell patients transferred from prisons for hospital treatment
- patients with organic mental illness admitted to hospital from their normal care environment

	The rationale for "as required" prescribing on admission must be recorded in the electronic patient record. In the absence of medical staff on the ward (e.g. over a weekend), the administration of second and subsequent doses of RT must be discussed with the duty doctor on-call and, if possible, the duty nurse co-ordinator. All prescriptions of RT medication must be reviewed within 72 hours of admission, and regularly thereafter, and discontinued when appropriate to do so
	After an RT event, an assessment should be made as to whether "as required" IM medication needs to be prescribed for further events, bearing in mind the patient's consent and MHA status. The prescription should be written in a way to ensure that repeat doses are not given without appropriate review and medical input.
	An episode of disturbed behaviour resulting in RT should be seen as an opportunity to review the patient's regular and PRN medication to improve control of their condition and management of future episodes.

15.3 Symptomatic relief & non-POM medicines

The inpatient prescription and administration chart includes pre-printed prescriptions for six medicines to treat minor ailments which a patient may experience whilst on a ward (e.g. mild pain, cough, dyspepsia). On admission, the prescriber can authorise the administration of all or a selection of these medicines for up to 3 consecutive days without the need for further prescriber consultation. If a medicine in this section is required for more than 3 consecutive days it must be prescribed on the "as required" section of the chart in order for administration to continue. It is then subject to review in line with standards for as required medicines

During periods of sunny weather, high factor sunscreen preparations do not need to be individually prescribed and may be applied or offered to patients without a prescription or prescriber review, provided this is documented in the care record.

15.4 Nicotine replacement therapy

On admission, every smoker should be offered NRT to manage their nicotine dependence within 30 minutes. The prescription and administration chart includes pre-printed prescriptions for seven NRT products which may be supplied by trained staff for up to 72 hours without a prescriber's signature but must be prescribed thereafter. Indicate the prescribed product by signing against it; if changed, cross through the product being stopped and sign next to the new product. Products not on the pre-printed list must be prescribed on the regular or as required section of the chart as appropriate.

16 Appropriate use of FP10 forms

FP10 forms may be used in the following settings:

- Outpatient clinics and other non-inpatient activity (FP10s preferred)

- Inpatient wards (for short-term unplanned leave/discharge or urgent need for inpatient supplies where the trust pharmacy is not open)

A system exists within the Trust whereby FP10 forms are readily available to prescribers to meet these needs.

The Trust recommends a maximum of 28 days' supply (or 30 days' – or more - to match original packs of some medication) is prescribed unless there are exceptional circumstances.

NOTE: F1 doctors cannot prescribe on a FP10 prescription

16.1 Medicines or circumstances for which FP10 forms may be used

- Any medicines for a psychiatric or related condition
- Newly initiated medicines or a change of dose or formulation to allow a patient to begin treatment without delay whilst written communication is sent to their GP
- When prescribing responsibility has not yet been transferred to the patient's GP
- In cases where the nature of the problem or the agreed status of the medicine necessitates the TEWV prescriber maintaining the supply (e.g. some RED drugs)
- Where an emergency supply of an existing treatment cannot otherwise be obtained

16.2 Transport of completed FP10 forms to community patients

Community staff (Registered Practitioners, Non Registered Practitioners, Nominated Volunteers or Allied Health Professionals), as part of their role in the clinical treatment of patients, may deliver FP10 forms as part of the overall care package. This aspect of care must be documented in the care plan and the patient must be known to the member of staff delivering the FP10 form.

A record of receipt of FP10 forms by community staff, and delivery and receipt of the FP10 form to the patient can be recorded on the electronic patient record (as the audit trail).

Any refusals to accept delivery must be documented in the patient's record. If FP10 forms cannot be delivered they must be returned to the community base on the same day and stored securely

A Trust identification badge should be worn or carried by all staff carrying FP10 forms.

FP10 forms must **never** be posted through letter boxes or left with a person unknown to the team.

FP10 forms may be transported to the patient's home by post. It is important that FP10 forms are packaged securely and clearly labelled with the destination.

16.3 Situations where an FP10 form is not considered appropriate

- For the routine supply of medicines for the patient's psychiatric or medical conditions which are normally prescribed by the GP
- For family and friends of patients
- For family, friends or personal use of Trust employees (in accordance with GMC recommendations)

17 Length of supply of medication

The Drug and Therapeutics Committee has agreed that the following amount of medication will normally be supplied:

- Leave prescription — Exact number of days or doses required
- Discharge prescription — Minimum 7 days, up to 28 days according to risk
- Outpatient prescription — 28 days (or 30 days for original packs)
- FP10 prescriptions — 28 days (or 30 days for original packs)

The Trust pharmacy service will dispense at least 7 days for discharge prescriptions and one month for all outpatient prescriptions unless a course of medication e.g. antibiotics, steroids is requested or a specific regime length of treatment is stipulated.

18 Safe Transfer of Prescribing

The safe and appropriate transfer of prescribing from in-patient to community services and from secondary care to primary care is covered by the Safe Transfer of Prescribing guidance.

19 Security of prescription stationery (FP10 prescription forms, leave/discharge and outpatient prescription forms)

Prescription stationery is controlled stationery and must be locked away when not in use. It should never be left unattended. Access should be restricted to authorised and designated staff only. Patients, temporary staff and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored

What is controlled stationery?

Controlled stationery includes all of the following:

- Yellow inpatient prescriptions
- Green leave/discharge prescriptions
- Pink pharmacy stock requisition book
- White outpatient prescriptions
- FP10 prescriptions
- Controlled Drugs requisition books
- Controlled Drugs registers

Where should controlled stationery be kept?

All controlled stationery should be locked away in a drawer, drug trolley, drug cupboard or filing cabinet.

Who should have access to controlled stationery?

Access to controlled stationery should be restricted to:

- Nursing staff (RN and HCA)
- Doctors
- Ward clerks
- Trust pharmacy team

N.B. doctors and ward clerks are not allowed access to drug trolley and cupboard keys, so if controlled stationery is kept in these nursing staff must ensure it is accessible

During clinics prescribers are advised to keep all prescription stationery out of sight in a locked drawer or briefcase, as appropriate, when not in use.

Prescription forms should under no circumstances be pre-signed before use.

Actual or suspected loss or theft of prescription stationery must be reported to the Chief Pharmacist and the Appointed Practitioner in Charge immediately so that appropriate action (e.g. notifying the police) can be taken to reduce the potential for fraudulent access to medicines. If the incident is noted on a weekend or Bank holiday the on-call pharmacist must be informed.

19.1 FP10 Prescription forms

See FP10 Prescription Management procedure for more details

In order to ensure the safe handling and custody of FP10 forms/pads the Trust has allocated specific codes for clinical teams throughout the Trust. Prescribers must only use the code allocated to them or their team. Consultants are responsible for controlling access to FP10 prescriptions by other medical staff in their teams.

Prescribers who hold their own FP10 pads are responsible for their security at all times and when visiting patients' homes, are advised to carry their pad in a locked briefcase in the boot of their car, as advised by the GMC.

Designated authorised signatories for receipt and storage of FP10 forms/pads for their teams must be registered with pharmacy.

The following details must be recorded in a stock control system when FP10 prescription forms are received or issued:

- Date of delivery
- Name of person accepting delivery
- Record of serial numbers of pads received (first and last number of the pad)
- Date of issue
- Name of person issuing the prescription forms
- Name of prescriber the prescription forms are being issued to
- Record of serial numbers of pads issued (first and last number of the pad)
- Records of serial numbers received and issued should be retained for 3 years

Disposal of unwanted prescription pads:

- Disposal of blank prescription forms must be witnessed

- The serial numbers of the prescription forms being disposed of must be recorded in the stock control system along with the name of the authorised person and witness
- Each prescription form must be torn into small pieces before being placed in a shredding bin

20 Prescribing controlled drugs

See Controlled Drugs Standard Operating Procedures for full details.

21 Prescribing for staff, family and friends

Medicines held on wards are for the use of patients only and must not be given to visitors or staff.

Prescribers (medical or non-medical) cannot issue a prescription for their own or their family's use.

Trust staff must obtain any drugs they need for their own treatment or for their families in the same way as other members of the public. Exceptions to this are vaccinations through national programmes and outbreak situations with multiple affected staff.

The Occupational Health service can be consulted in the event of illness occurring while on duty.

Staff requiring treatment for minor ailments may obtain advice from Occupational Health or a local community pharmacy where they can also purchase any necessary items.

22 Appendix 1: Position Statement on Nurses giving prescribing advice to GPs, Acute Trust prescribers and Non-Medical prescribers

It is acknowledged that in some services Registered Nurses (RNs) give prescribing advice to GPs, Acute Trust prescribers or Non-Medical prescribers. This will be supported within the following parameters:

RNs who are prescribers – may give independent advice on prescribing within their approved scope of practice; if outside of their scope of practice they must follow the parameters of RNs who are not prescribers.

RNs who are not prescribers – may give advice which follows the direction of either national or trust prescribing guidance, or relay advice from a trust prescriber with the following stipulations:

- The RN cannot give advice independently, they must use one of the above sources of reference
- Whether providing verbal or written advice, the RN **must** state the source of the advice i.e. the name of the prescriber or state the name of the NICE or trust prescribing guidance document
- Verbal advice must always be followed with an instruction “not to act on verbal advice until written confirmation has been received”
- Any verbal advice provided must be immediately backed up with written advice via NHS mail
- The advice given and the reference source must be clearly documented in the electronic patient record
- Prescribers providing advice must either make their own entry in the clinical record or validate the entry made by the RN

Examples of how to communicate this information in writing are suggested below:

- “This prescribing recommendation is provided following a discussion with NAME OF PRESCRIBER, who is a trust authorised prescriber “

OR

- “This prescribing recommendation is based on information contained in NAME OF NICE OR TRUST PRESCRIBING GUIDANCE DOCUMENT”

23 Appendix 2 - Standards for re-writing prescription charts

The function of the prescription and administration chart, or equivalent, is to:

- Provide a permanent record of the patient's treatment with medicines
- Indicate the patients' sensitivity to medicines
- Direct and record the administration of the medicines to the patient

A well-written prescription and administration chart enables the rapid and accurate interpretation of the medicines required by the patient. All prescriptions must be in black ink and written in block letters to facilitate legible scanning or copying. The administration record lasts for a maximum of 12 weeks for regular medication, after this period treatment must be re-written if it is to be continued. (If there are less than 7 prescriptions for regular medication, these may be rewritten into section 2 of regular medication of the same chart provided the entries in section one are clearly discontinued).
The administration record lasts for a maximum of 56 doses of up to 12 "as required" medications.

RISKS!

- **Multiple prescription and administration charts increase the potential for administration and prescription errors**
- **Prescribers should limit the number of prescription and administration charts in use for any patient to the minimum number required**
- **Wherever possible this should be restricted to a single chart**

STANDARDS FOR THE NUMBER OF CHARTS IN USE

No more than one chart if 10 or less regular prescriptions
No more than two charts if 20 or less regular prescriptions

(If separate PRN charts are used the above standards for the number of charts in use also apply.)

ACTIONS

When a new prescription and administration chart is needed, **all** currently prescribed medicines must be transcribed by the prescriber onto a new chart along with all relevant annotations.

- The date when the medication was originally prescribed should be entered as the start date
- The date that the prescription chart was re-written should be clearly noted on the front of the prescription and administration chart in the 'date chart started/rewritten' box
- The old chart must be cancelled by drawing a diagonal line across the front and writing CANCELLED across it
- Where more than one chart is in use, the second chart must remain with the first. Both drug prescription and administration charts must indicate the existence of a second chart.

As soon as possible multiple prescription and administration charts should be condensed onto one chart.
The old chart should be retained with the new, re-written chart for 24 hours to inform appropriate administration of as required and symptomatic relief medicines in line with prescribed / approved dose intervals

RESPONSIBILITIES

The prescriber is also responsible for rewriting the entire prescription and administration chart: -

- if the chart has become unclear or ambiguous due to multiple deletions and revisions
- at the request of the practitioner responsible for administration or a pharmacist or pharmacy technician when they become untidy especially after medications have been stopped and/or changed or risk with administration errors are identified

USEFUL TIPS

- **Avoid the need to have charts re-written at weekends or out of hours by anticipating and planning ahead. There is a reminder printed on the administration record two weeks before regular medication is due to be rewritten.**
- **Prescribe medicines for physical heath first on the chart, these are less likely to change and reduces the frequency for re-writing charts**

24 Appendix 3: A guide to recording in the electronic patient record

Section 14.3 of this procedure states:

A record of medicines prescribed, stopped or changed must be recorded on the electronic patient record.

The standard for recording information about medicines on the electronic patient record and in any communication with GPs should follow the general principles for prescribing described above. As a minimum the following should be clearly described in the electronic care record for newly initiated medication.

- **Details of the medication prescribed** (including drug, indication, form, dose and quantity)
- **Rationale for the decision** (include key factors in decisions making – see section 3)
- **Patient information provided** (describe level of shared decision making and note information provided– to patient / family / carer – including any significant discussion points)
- **Treatment plan** (as appropriate describe plans for review, monitoring of effectiveness, physical health monitoring, next steps)

It is recommended that this information is recorded as a "Medication Treatment Plan" case note.

Section 3 describes some of the factors to consider when initiating or changing medication. A template is already available if this information is recorded as a "medication treatment plan" in Paris. The following is a guide to where information could be recorded (if appropriate).

Medication Entry:

Drug, form, dose and quantity

Diagnosis:

Pull through the appropriate diagnosis or include the indication here if not directly related to an established diagnosis

Rationale for current plan:

Consideration of the benefits vs. risks and a rationale for the choice. Describe any associated evidence for the treatment (if outside of guidelines). Rationale and consent when prescribing off-label / unlicensed medicines.

Note any specific risks addressed / considered including; age, other health conditions, side effects / adverse events, contra-indications, cautions, other medications including illicit, complementary and over the counter, drug & other interactions, smoking, alcohol, caffeine intake, pregnancy or breast feeding, hepatic or renal impairment, substance misuse, overdose risks

Prescribing / Monitoring / Reviewing Arrangements:

Polypharmacy (over-prescribing / STOMP) & deprescribing of existing medication.

Planned duration of treatment

Process of titrating (and cross-titration) / reducing / stopping medication (deprescribing)

Required monitoring / planned review:

Physical health monitoring

Discussion undertaken with patient:

Describe the level of shared decision making and patient choice. What options were discussed. What appropriate information was provided for the patient, family and carers. Consent issues. Any discussion re: Medicines adherence

Next steps:

Review of impact / effect of medication & potential process of transfer of prescribing (if applicable)

25 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	24 November 2022
Next review date	01 April 2024
This document replaces	Prescribing and initiation of treatment PHARM-0002-001-v3.1
This document was approved by	Drug and Therapeutics Committee
This document was approved	24 November 2022
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	See generic EA for pharmacy documents
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1.1	16 Feb 2015	Amendments to controlled stationery	Superseded
1.2	16 Apr 2015	Amendments to controlled stationery	Superseded
1.3	28 Jul 2016	Amendments to section 8 & 9 (verbal orders and remote orders)	Superseded
2.0	May 2018	Full review and update	Superseded
2.1	26 Sep 2019	Removed reference to Paris (changed to electronic clinical record) and removed references to Lloyds / third party contracted pharmacy	Superseded
2.2	18 Nov 2019	28 days supply limit on CD prescriptions amended to 30 days	Superseded
3.0	25 Mar 2021	Full review & update: removed all references to faxes, added Physician associate to medical student box, FP10 info updated, Safe transfer of prescribing section added, controlled drugs info removed with signpost to controlled drugs SOP, RT box updated, updated the formulary info to include NY&Y, removed reference to IVs and Birch ward, added pharmacy technician to Appendix 2.	Superseded
3.1	23 Jun 21	Minor amendment to section 9 (verbal order to supply. New section 10 to support verbal orders to administer medicines in a medical emergency.	Superseded

		Page 15 – dose titration information added in	
3.2	24 Nov 22	Enhanced and expended section 3 for starting medication. Additional info in box on page 4. New "audit standards" in section 14.3. Appendix 3 added to support section 14.3. Other amends throughout to align with other recent procedure changes. Wound care reference in section 4.2. Below two changes are to be approved retrospectively at next D&T meeting as agreed by Chief Pharmacist: • OJTC text added to Purpose section. • Removed job titles following organisational restructure	Approved

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	y	
2.	**Rationale**		
	Are reasons for development of the document stated?	y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	N	Included in medicines overarching framework
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	N	Included in medicines overarching framework

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	n/a	Part of generic overarching EA
	Have Equality and Diversity reviewed and approved the equality analysis?	n/a	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the document been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	na	