Public – To be published on the Trust external website

Title: Medicine Administration Record (MAR) Chart – Procedure for use

Ref: PHARM-0054-v4

Status: APPROVED
Document type: Procedure
Overarching Policy: Medicines Overarching Framework

Contents

1 Introduction

This procedure is needed to give practitioners on respite units a framework and guidance on using Medicine Administration Record (MAR) charts. It promotes safe practice in the activities of writing and checking MAR charts and reconciling medicines written on the MAR charts. It covers risk, safety, and legality to help ensure that our patients receive the safest care we can provide.

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

2 Purpose

Following this procedure will help the Trust to:

- Define when the use of Medicines Administration Record charts (MAR) is appropriate.
- Ensure clinicians using MAR charts do so appropriately and adhere to required parameters
- provide a standardised approach across all respite units within TEWV when using MAR charts and guidance to staff involved with these processes.

3 Who this procedure applies to

- This procedure applies to practitioners working on respite units where MAR charts are used.

4 Related documents

This procedure describes what you need to do to implement the administration in respite care section of the Medicines Overarching Framework

The Medicines Overarching Framework defines **Administration in respite care or community residential units using medicines supplied via the GP or patient's own supplies.** Staff must consult this information before carrying out the procedures described in this document.

This procedure also refers to:

- ✓ Patient own drugs (PODs) procedure for use
- ✓ Medicines reconciliation procedure

5 Function and process of MAR charts

There are some TEWV services which receive medical and prescribing services from external providers; however the administration of medicines remains the responsibility of Trust staff. To accommodate these situations an agreed process is required to record administration of medicines that are not prescribed by Trust staff.

The function of a MAR chart is to provide a permanent record of the patients' treatment with medicines whilst in the care of the Trust; to direct and record the administration of the medicine to a patient.

A MAR chart is not a prescription – medicine supplies cannot be requested against a MAR chart

5.1 Appropriate services

MAR charts may be used in services where medicines are administered by Trust employees and:

- There is no regular Trust prescriber available to the service.
- Supplies are obtained via the GP or a prescriber external to the Trust.
- PODs are used (see Patient Own Drugs (PODs) Procedure).

These services include respite units and residential care units.

5.2 Who can write a MAR chart

Only RNs (Registered Nurses) appropriately trained and accredited in the use of PODs and MAR charts can write and check MAR charts.

5.2.1 Training

MAR training will only be offered to appropriate services.

- RNs must have successfully completed and passed the POD training before being able to access MAR training.
- RNs must successfully complete the MAR training module, which will include a practical assessment to enable writing and checking MAR charts.
- The training will be facilitated by the Lead Pharmacy Technician - Medication Safety (LPTMS).
- A record of completion must be kept on their personal file with a central record held by the Team/Ward Manager.
- A central record of all accredited RN MAR Chart writers and checkers will be held by the LPTMS.

5.2.2 Reaccreditation for RNs

- Reaccreditation is not required for RNs working on units that operate a MAR & POD system.
- If an error occurs, the error will be reported on InPhase and reflection should be undertaken. If there are a number of errors or a theme in errors, the RN will be given the opportunity to re-train with the LPTMS.

5.2.3 Student nurses

With regards to Patients' Own Drugs (PODs) and Medicine Administration Records (MAR), student nurses may:

- be involved in the administration of medicines against a MAR chart, using PODs, under the direct supervision of a suitably accredited DP.
- observe the process of POD assessment for suitability of use but cannot be directly involved.

Student nurses cannot:

- write, or check medications written on a MAR chart.

5.2.4 Preceptorship and Bank RNs

- Preceptorship and Bank RNs will not be able to access MAR chart training. It is the responsibility of the service manager to ensure there is appropriately trained staff on duty with preceptorship and bank nurses to support service delivery.

5.2.5 Pharmacy Staff

- Designated pharmacy technicians and pharmacists may be trained to write and check MAR charts as per service need.

5.2.6 Nursing associates (NA's)

- May be involved in the administration of medicines against a MAR chart, using PODs.
- NAs cannot assess PODs for suitability.
- Cannot write or check medicines written on a MAR chart

5.3 Transcribing

For medicines, the Royal Pharmaceutical Society (RPS) and the Royal College of Nurses (RCN) define transcribing as the accurate copying of previously prescribed medicines details to enable their administration in line with legislation (i.e., in accordance with the instructions of a prescriber).

Transcribing is the exact copying of medicines details for the purposes of administration only.

It cannot be used:

- in place of prescribing
- to supply or dispense medicines.
- to alter or change original prescriptions.

Where prescribing instructions are not clear e.g. “as directed” on the label, this will need clarification from the prescriber as to how the medicines should be administered to then transcribe the instructions onto the MAR chart.

5.4 Process for using a MAR chart

- MAR charts should be ordered via Cardea **LP182233**
- A MAR chart should adhere to the standards for recording the prescription on the front of the MAR chart.
- Medicines must not be written up on a MAR chart or administered if supporting information from the prescriber is not available.
- An independent RN check is required but does not have to be completed simultaneously to the writing of the drug chart. It does however have to be completed and signed for prior to the first administration of any medicine.
- Evidence must be obtained from every prescriber involved with prescribing medicines, with the exception of OTC (Over The Counter) medicines, which will be a signed and dated photocopy of the OTC POD or a printout of the leaflet from Home - electronic medicines compendium (emc) or MHRA (Medicines & Healthcare products Regulatory Agency) , the information must match the brand being used
- Sources of information include written information from the parent/carer (see Appendix 1), written information from **all** prescribers confirming the current medicine and dose e.g., computer print-out from a GP records system, a letter from the prescriber, printed information from the EPR entered by the prescriber, copy of the most recent FP10 prescription or repeat request slip, patient own supply (i.e. medicine label), Care Record, hospital discharge letter.
- Evidence of completion of the checks must be maintained, this should be kept alongside the MAR chart with an entry made into the EPR.
- The medicine dose and frequency from all sources must match; if these do not match the RN should contact the lead prescriber (usually the GP) and clarify any anomalies asking for written confirmation and documenting any action taken in the EPR.
- All medicines including prescribed nutritional supplements and oxygen must be written on the MAR chart and relevant supplementary charts used
- Allergy status must be checked and confirmed each admission and each time medicines reconciliation is completed.
- Any additional protocols, such as prn treatment for epilepsy, bowel protocols, asthma rescue medicines should be reviewed on a yearly basis or sooner if notified of a change. Good practice would be to add a section to the bottom of the protocol stating date reviewed and by who when no changes are needed on the protocol. The named nurse and parent/carer should agree and sign the protocol, with the administration instructions being documented within the prescription.

- The authorised RN(s) should only include medicines to be administered whilst the client is in the care of the service on the MAR chart.

5.5 New admission

- For the first admission to any service using MAR charts, a history of medicines previously prescribed and allergy/sensitivity status should be accessed and recorded comprehensively in the patient's notes.
- A process of medicines reconciliation must be completed.
- An entry for medicines reconciliation must be documented in the EPR.
- An entry must be made on the MAR chart stating medicines reconciliation completed, signed, and dated by the RN completing it.
- For all medicines on the MAR chart original start dates of prescription should be included where known. If not known, then the first date the MAR chart was written or first issue date on GP information should be used as the start date.
- Prior to the first visit/admission to service the MAR chart should be written by an authorised RN using a minimum of TWO sources of information. The chart should then be independently checked by another authorised RN to confirm the accuracy of the information.
- Current sources of evidence of prescribing should be kept with the MAR chart in use

5.5.1 Subsequent admissions

- Medicines reconciliation should be completed six monthly using a minimum of two sources.
- If informed of any changes to prescribed medicines, the full medicine reconciliation process must be completed as soon as practicable and documented on EPR and noted on the MAR chart.
- If a patient is regularly admitted to/attending a service then the same MAR chart can continue to be used providing all of the required checks have been completed prior to recommencement of the chart.
- Sources of information superseded by a notification of change and/or medicines reconciliation should be filed in the patient's paper notes.

5.6 OTC (over the counter) medicines

- OTC medicines can be written on the MAR chart providing confirmation from the carer/parent has been obtained.
- Parent/Carer must complete the PRN or regular OTC section on the medicines invite letter. Please see carer letter, appendix one & two.
- Dosage and frequency of administration must be within the administration guidance on the packaging.
- Check there are no interactions with any prescribed medicines e.g., paracetamol containing products.
- OTC medicines must be brought into the unit in the original packaging.
- Medicines should be written on the MAR chart as per the MAR procedure, written and checked by two RNs who have completed MAR training. Please note the sources of

evidence will be the carer/parent medicines letter and a signed and dated photocopy of the OTC POD or a printout of the leaflet from Home - electronic medicines compendium (emc) or MHRA (Medicines & Healthcare products Regulatory Agency), the information must match the brand being used.

- Nurses must always check allergies and sensitivities before writing OTC medicines onto a MAR chart.
- Nurses are advised to consult the appropriate current BNFC or BNF regarding interactions with currently prescribed medicines.

5.7 Patient Identification

- Photographs are used to help identify patients when administering medicines and to reduce the risk of administration of medicine to the wrong patient. This is a mandatory admission process for all inpatient areas where medicines are administered.
- For units using MAR charts, obtaining a patient photo will be part of the preadmission process. Advise the parent/carer that the photo will be attached to their MAR chart and is a measure to support the safe administration of their medicines.
- If the parent/carer agrees to photo:
    - Take a photo using identified ward device, print off and laminate if required.
    - Immediately delete photo from device if required (device dependent).
- It is accepted that there may be times when parents/carers refuse the request of a photo. In those cases additional identification checks will be implemented. The refusal of the photo should be documented on the MAR chart by making a small note on the photo box section with the date as well as a corresponding entry in the EPR.
- Consider alternative identification method- and document on the front of the MAR chart. Visual recognition and verbal open questioning – asking for the patient demographics (full name, DOB) or ID wristbands. If medicines are being administered by a bank nurse or a nurse unfamiliar with the patient a second person familiar with the patient **must** assist with identification.
- Ensure follow up with the parent/carer occurs and document in the EPR. Each area should have access to an instant camera and refill cartridges can be ordered via Cardea. Stock levels should be checked and maintained to ensure cartridges are always available.
- Each area should have a clear process to always enable access to the ward camera.
- For rewritten MAR charts, the photo can be moved to the new chart providing there are no obvious changes to appearance.
- Photographs should only be updated and replaced on charts when any changes to physical appearance e.g., hairstyle, facial hair etc are noted.
- Processes should be in place in each area to always allow access to cameras.

5.8 Medication reconciliation recording

- When undertaking medicines reconciliation, this must be documented using the “med rec e-form - Respite” in the EPR. The med rec must include all medicines including feeds and OTC medicines which are administered to the patient.
- An entry must be made on the MAR chart stating medicines reconciliation completed, signed, and dated by the RN completing it.

- Any queries should be documented in the query section of the medicines reconciliation template, queries must be followed up and any actions taken to resolve them added to this section.
- The free-text section of the template must include the following information.
    - Medicines and allergy status checked and confirmed using the following sources of information (sources should be listed with relevant dates)

5.9 Provision of medicines

All Parents/carers should receive information related to their role and responsibility for the provision of medicines including any issues if the correct medicines are not provided.

- For patients admitted into respite care, RN(s) should confirm with the carers prior to admission that:
    - The necessary medicines to span the period of admission will be provided; the period for this check to be completed should be locally agreed and documented in the Standard Process Description (SPD) for preadmission.
    - Any changes to prescribed medicines are communicated to the unit in a timely manner.

- All supplies of medicines must meet the requirements for using PODs except where there are frequent dose changes, and the medicine supply is not labelled with the current dose e.g. dose titration. In this instance the supply can be used if there is written evidence from the prescriber for the appropriate dose and the MAR chart contains the correct information (All other POD assessment criteria must be met). A copy of this evidence should be held alongside the MAR chart and an entry must be made in the EPR. **RNs cannot alter or amend dispensing labels.** This should be documented on the POD assessment record and a yellow sticker applied to the medicine.
- At the end of the stay all remaining medicines must be returned home with the patient. The quantity returned should be documented on the POD assessment record which should then be filed in the patient's paper notes.
- If the medicines are unsuitable for use or there are insufficient supplies to last the planned stay, the patient **cannot** be admitted. Where this is not an option due to the patient's circumstances, seek advice from the pharmacy team or the on-call pharmacist (if out of hours).

5.10 Residential care units (367 Thornaby Road)

For patients in residential care local arrangements should be made to access medicines against the prescription provided by the GP or prescriber external to the Trust with a printed MAR chart being produced and supplied by the community pharmacy.

5.11 Transitioning from children to adult services

- If a child attending children's respite service transitions to adult LD respite service. A copy of the following should be sent to the new service to help support the preparation of the MAR chart.

- MAR chart
- Any protocols; epilepsy, bowel, asthma rescue plan, dietetic regimes etc. please note some may need to be removed or amended when moving from child to adult age.
- Most recent prescribing evidence from all prescribers involved in the patient's care.
- Most recent parent/carer letter.
- Any recent photocopies of any OTC medicines information.

Relevant checks will still need to occur, do not copy directly from one MAR chart to a new one.

5.12 Receiving and sending information

- If carer letters are sent or received. The email procedure is to be followed. Email Procedure
- When the carer letter is received via email, the whole letter and email should be printed and stored securely with the MAR chart as this confirms admission period on the unit.

5.13 Security of medicines

- All medicines must be stored securely and adhere to the parameters in the Medicines Overarching Framework
- When patients are transported to the service by either a Trust employee or an individual contracted by the Trust, they should be informed of parameters required to adhere to the security of medicines as identified in the Medicines Overarching Framework.

5.14 Reducing the risk

- Use of concurrent MAR charts increases the risk of administration errors. RNs should limit the number of MAR charts in use.
- If more than one MAR chart is in use, they should be held together, and each should indicate the existence of the other. Where possible, i.e. if some medicines are discontinued, multiple MAR charts should be condensed into one.
- The MAR chart should be rewritten in full if it becomes unclear or ambiguous.
- Where there is any doubt about the medicine to be administered the RN should withhold and contact the relevant prescriber for further clarification in writing. This must be documented in the EPR.

When a new MAR chart is required the RN(s) **must** comply fully with the standards and safeguards for checking medicines prescribed against sources of information; they **must not** copy across from one MAR chart to another

5.15 Emergency treatment

- If a patient becomes unwell during a respite stay seek advice from GP/111 or A&E dependent on urgency.

- If medicines are prescribed and a prescription is supplied.
  - The unit should arrange for the prescription to be dispensed at a pharmacy.
  - Inform the parents or carers and add a note to the EPR.
  - Photocopy the pharmacy dispensing label on the medicine container, print and sign the photocopy. Keep the evidence with the MAR chart.
  - A RN who has been accredited to write medicines on a MAR chart can write this on the MAR chart.
  - A second RN should then check the medicine written on the MAR chart.

If there is no RN trained in checking MAR charts available at this time, the entry **must** be checked and signed by an accredited checker within 24 hours. Good practice would be to have another staff member check the entry matches the medicine label and a note should be added to EPR. Medicines in this instance can be administered against the one signature.

5.16 Audit

- Lead Pharmacy Technician Medication Safety (LPTMS) will audit the standards for writing and checking MAR charts as well sampling medicines reconciliation entries on the EPR.

5.17 Errors

- An incident form must be completed for any errors involving MAR charts. Staff involved must reflect on the error in clinical supervision.

6 Definitions

Term	Definition
DP	Designated Practitioner
EPR	Electronic Patient Record
MAR	Medicines administration record
Medicines reconciliation	Medicines reconciliation involves collecting and documenting relevant information about all current medicines prescribed for the patient from all/any services involved in their care

NA	Nursing Associate
OTC	Over the counter (OTC) refers to a medicine that can be purchased without a prescription
Prescriber external to the Trust	A prescriber not employed by the Trust but who is responsible for the provision of medicines, e.g. GP
POD	Patients own drug(s)
PRN	Pro Re Nata – "as required"
RN	Registered nurse
LPTMS	Lead Pharmacy Technician - Medication Safety
MHRA	Medicines & Healthcare products Regulatory Agency
NA	Nursing Associate

7 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all staff working on units that operate a MAR system.
- Via MAR training for Registered Nurses

7.1 Training needs analysis

See Medicines Overarching Framework Policy

8 How the implementation of this procedure will be monitored

See Medicines Overarching Framework Policy

9 References

RCN Medicines Management An overview for nursing 2020
Medicines Overarching Framework
Patients Own Drugs (PODs) procedure for reuse
Medicines Reconciliation Policy

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	28 March, 2024
Next review date	28 March 2027
This document replaces	PHARM-0054-v3.1 MAR Chart procedure
This document was approved by	Drug & Therapeutic Committee
This document was approved	28 March 2024
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	See Medicines Overarching Framework
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1.0	09 Jan 2014		Superseded
2.0	30 Sep 2016	Reviewed	Superseded
2.0	26 Jan 2017	Approved	Superseded
2.1	17 April 2019	Paragraph added to reflect OTC medication	Superseded
3.0	16 Dec 2019	Reviewed. Added medicine reconciliation recording. Removed appendix 3	Superseded
3.1	22 Sept 2022	Update. Amended re accreditation of RNs and added audit section	Superseded
4.0	28 March 2024	Full review Updates include: role of Nursing Associates; Transcribing – definition, when it can/cannot be used; Patient identification – promoting use of photographs; Medicines reconciliation process – use of e-form on Cito; transition from child to adult respite services; emergency treatment	Approved

Appendix 1 – Parent / Carer letter confirming prescribed medicines (Adult respite)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust
Unit 2 Bankfields
Bankfields Court
Normanby
Middlesbrough
TS6 0NP
Tel: 01642 283752

Date:

Private & Confidential

Dear …….

Regarding: Medication

We would like to offer respite at Unit 2 to :-
Between the dates of …….. and ……..

Your Admission Time is:

On this unit, we operate a policy of using the patient's medicines from home. Any medicines used will be for the patient's treatment only and at the end of the stay all remaining medicines will be returned home. The unit is also a nurse led unit, where the nursing team write medicines on the medicines administration record chart.

It is important that we have an accurate list of medicines and allergy status for the patient, to enable our team to write the medicine on the medicines administration record chart. The medicine list attached is a record of the medicines written on our medicines administration record chart from the patient's previous admission. **Each medicine and allergy status must be checked and signed for to ensure accuracy.**
The unit must be informed of any changes to medicines/allergy status at the point of the change being made; this is to allow the team to gather information from the prescriber and yourself to enable this to be written on the medicines administration record chart. If the prescriber cannot be contacted for information to confirm the change the team are unable to write the medicines on the chart.

Please bring the patients medicines, in the original packaging along with this form, to the unit on the admission date, and ensure there is enough for the duration of their stay. You will be allocated a time slot to check in to the unit, to allow checks to happen on the medicines. **If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay, the patient cannot be admitted.**

The client's admission is subject to

- **The unit being informed of changes to medicines and allergy status 72 hours**

- **before admission.**
- **The unit being able to obtain evidence from the prescribers to enable the medicines to be written and checked on the medicines administration record chart.**
- **The medicine being assessed as suitable to use for the patient.**

Kind regards,….

Bankfields Unit 2

Please check allergy status, each medicine and sign if this is correct (highlighted in grey). If incorrect, please make any changes, as necessary.

NB. IT IS IMPORTANT THAT THE PARENT/CARER INFORMS THE GP ABOUT THE PATIENTS ALLERGIES AND SENSITIVITIES.

I AM CONFIRMING ALLERGY STATUS AND ALL MEDICINES LISTED BELOW IS CURRENT AND CORRECT.

Patient/Carer signature: Date:

Print Name :: Telephone number::

Allergies & Sensitivities	Date of Confirmation	List Any new allergies	Nurse sign	Patient/ Carer signature

Prescribed Regular medicines (name, form, and strength)	Dose	Times administered	Nurse sign/comments	Parent/carer sign if correct or mark if wrong

Prescribed As Required medicines

Over The Counter (regular medicines)

Over The Counter (as required medicines)

Appendix 2 – Parent / Carer letter confirming prescribed medicines (Childrens respite)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Date

Address

Dear

Re: RESPITE ADMISSION INVITATION & MEDICINES INFORMATION

We would like to offer respite to: **Name** **D.O.B**

On: ……Your check in time slot is **:……**hours this will take up to 30 minutes.

On rare occasions we may need to cancel or rearrange the above admission. This may be because another child requires an emergency admission, or we are unable to staff the unit safely. Any cancellation is not made unless necessary. If possible, we will offer a substitute date/s.

On this unit, we operate a policy of using the child's medicines from home. Any medicines used will be for the child's treatment only and at the end of the stay all remaining medicines will require collection.

I give consent for: (please delete anything you do not give consent for):

1. **Sudocrem (for nappy rash and dry skin) and sunscreen to be used, as necessary.**
2. **Student nurses to be involved during my child's stay.**
3. **Picture display photos of my child to be taken for use within …….**
4. **A visual monitor or sound monitor to be in my child's bedroom for safety purposes.**
5. **Information to be shared with other professionals involved with my child's care on a need-to-know basis.**
6. **Participation in activities, including trips supervised off the unit.**
7. **MSA Requirements**

We recommend that you pack the following items for your child's stay:

- **Medicines**
- **Any medical equipment that the child requires.**
- **Any nutritional supplements and feeds.**
- **Change of clothing and underwear**
- **Incontinence pads if required.**
- **Spare pyjamas**
- **Toiletries**

- **Preferred toys**

The unit is also a nurse led unit, where the nursing team write medicines on the medicine administration record chart.

It is important that we have an accurate list of medicines and allergy status for the child, to enable our team to write the medicines on the medicines administration record chart. The medicine list attached is a record of the medicines written on our medicines administration record chart from your child's previous admission. **Each medicine and allergy status must be checked and signed for to ensure accuracy.**

The unit must be informed of any changes to medicines/allergy status at the point of the change being made; this is to allow the team to gather information from the prescriber and yourself to enable this to be written on the Medicines administration record chart. If the prescriber cannot be contacted for information to confirm the change the team are unable to write the medicine on the chart.

Please bring your child's medicine, in the original packaging along with this form, to the unit on your child's admission date, and ensure there is enough for the duration of their stay. You will be allocated a time slot to check in to the unit, to allow checks to happen on the medicines. **If the medicines are unsuitable for use or there is an insufficient supply to last the planned stay, your child cannot be admitted.**

Your child's admission is subject to

- **The unit being informed of changes to medicines and allergy status 72 hours before admission.**
- **The unit being able to obtain evidence from the prescribers to enable the medicine to be written and checked on the Medicines administration record chart.**
- **The medicines being assessed as suitable to use for your child.**

Yours sincerely,

……. Unit

Please check allergy status, each medicine and sign if this is correct (highlighted in grey). If incorrect, please make any changes, as necessary.

NB. IT IS IMPORTANT THAT YOU INFORM YOUR GP OF ANY ALLERGIES AND SENSITIVITIES.

Allergies & sensitivities	Date of confirmation	Patient/Carer signature	Please list any new allergies

Medicine Name, Form, strength	Dose	Time administered	PARENT/CARER SIGN IF CORRECT OR MARK IF WRONG	NURSE SIGN IF CORRECT OR MARK IF WRONG
As required medication				
Over the counter medicine - regular				
Over the counter medicines – when required				

Patient / Carer signature: Date:

Name in full: Telephone number/s:

Appendix 3 - Assessment of competency for writing and checking MAR charts

Assessment no. 1

Write and check five MAR charts

Pass **Fail**

↓

Assessment no. 2

Write and check relevant number of MAR charts**

Pass **Fail**

↓

Assessment no. 3

Write and check relevant number of MAR charts**

Pass **Fail**

↓

Unable to write or check MAR charts

↓

Actions –

- Personal reflection,
- Shadow accredited MAR writer and checker for three months, Supervision.
- After all of the above has been actioned, a further assessment of writing and checking five MAR charts will occur.

** This is dependent on how many written or checked MAR charts are passed in each previous assessment. E.g. if 3/5 written MAR charts are passed then on the next assessment two would need to be written. Same principle for checking MAR charts in each assessment.

Appendix 4 – Approval checklist

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

7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	NO	SEE MEDICINES OVERARCHING FRAMEWORK
Have Equality and Diversity reviewed and approved the equality analysis?	N/A	
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	NO HARM
Does the document identify whether it is private or public?	Yes	PUBLIC
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	