Public – To be published on the Trust external website

Title: Supporting Staff and Learning from Medication Incidents

Ref: PHARM-0045-v4

Status: Approved

Document type: Procedure
Overarching Policy: Medicines Overarching Framework

Contents

1 Introduction

This procedure supports Our Journey To Change (OJTC) as set out in the Medicines Overarching Framework Policy

Patient Safety incidents are 'Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm' ' (NHS England, 2023). Medication errors are the single most preventable cause of patient harm.

Incidents reported within TEWV are recorded on the Trusts incident management system (In Phase). To note, InPhase refers to incidents as 'events', for the purpose of this procedure in line with language used elsewhere, we will continue to refer to these as incidents. These are also automatically recorded via the Learn from Patient Safety Events (LFPSE) service. The LFPSE analyses patient safety events that occur in any healthcare setting.

Reporting incidents provides valuable learning to make the NHS safer for patients. As per the NHS Patient Safety Strategy, to improve safety we must recognise where things go wrong and to make progress, we must significantly improve the way we learn, treat staff, and involve patients. As a Trust, we need to ensure we operate in a fair and just way, so that staff feel able to be open and honest about when incidents occur without fear of blame. It is recognised that staff may experience emotional distress or wellbeing issues because of patient safety incidents. (HSSIB 2021) This needs to be considered when supporting staff following such incidents.

PSIRF (Patient Safety Incident Response Framework) (NHS England) was fully embraced in the Trust in January 2024. This framework replaces the Serious Incident framework of 2015. It supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.

2. Application of a range of system-based approached to learning from patient safety incidents.

3. Considered and proportionate responses to patient safety incidents

4. Supportive oversight focused on strengthening response system functioning and improvement.

The Trust supports a "Just Culture" approach with staff following medication incidents, 'A Just Culture Guide' (Appendix 1) is a support tool to aid discussions.

2 Purpose

This document has been developed to provide guidance and a defined pathway for all staff involved in medication incidents. The aim is to increase consistency in supporting staff involved in

medicine incidents or errors. The aim of incident reporting is not to assign blame, but to learn from incidents, with the purpose of reducing the risk of future errors.

A just culture encourages balanced accountability between organisations and individuals, and application of systems-thinking principles to allow fair and just responses to adverse events. There may be occasions where a reported incident requires further in-depth exploration. If required, this policy should be used in conjunction with the Trust's Incident reporting and serious incident review policy, Managing concerns of potential conduct (Disciplinary) Procedure, Managing Concerns of Potential Poor Performance (Capability) Procedure and Dealing with concerns affecting Medical Staff which set out the appropriate processes and procedures to formally deal with issues raised.

Following a reported incident, regardless of severity level it is essential that the staff are appropriately supported by line managers, involved in any subsequent investigation, and advised of the investigation outcomes and recommended changes to practice.

There will be an open and supportive approach with an emphasis on discovering and addressing different aspects of an incident through a thorough analysis of all the contributory interacting factors such as the environment, systems or external influences and the interactions these have had which has resulted in an error occurring.

Following this procedure will help the Trust to:

- implement a systematic response to medication errors and incidents to enable the identification of individual and organisational failures and
- reduce adverse patient outcomes.
- identify themes, trends and learning from incidents.

3 Who this procedure applies to

This document covers all staff involved with medicine management, irrespective of setting, designation, or profession. It covers all stages of medicine management, including storage, administration and prescribing It has been developed to provide a standardised approach to supporting staff involved in medication incidents. It offers a structure to encourage staff to report all medication incidents within a framework that promotes professional development and patient safety without fear of retribution. It enables identification of operational and systemic failures that may have resulted in, or contributed to, medication incidents.

4 Related documents

This procedure describes what you need to do to implement section 4.1.10 of the Medicines Overarching Framework (MOF).

The MOF states that medication errors are identified, recorded, and monitored appropriately reported and investigated according to Trust's Incident reporting and serious incident review policy

This procedure also refers to:-

- ✓ Medicines – Prescribing and Initiation of Treatment
- ✓ Incident reporting and serious incident review policy
- ✓ Managing concerns of potential conduct (Disciplinary) Procedure
- ✓ Managing concerns of potential poor performance (Capability) Procedure
- ✓ Dealing with concerns affecting Medical Staff
- ✓ Safeguarding Adults Policy
- ✓ Safeguarding Children Policy

5 Roles and responsibilities

Role	Responsibility
Managers	Are responsible for ensuring this guidance is accessible to staff and implemented across the services for which they are responsible. This involves supporting individuals following incidents and signposting to other sources of advice and support were necessary.
Pharmacy Medication Safety Team- consisting of Medication Safety Officer (MSO), Lead Pharmacy Technician- Medication Safety and two Medicines Management Nurses	Improve medication incident reporting, review trends, and share learning. Review medication incident reporting within the organisation and improve the quality of medication incident reporting which feeds into LFPSE. To identify and implement medication safety initiatives. To help to reduce medicines related risks. Work towards ensuring safe medication practice in the Trust and across the primary and secondary interface considering the quality, safety and governance issues related to the use of medicines. The development and implementation of policies, procedures, and guidance for medicines safety, as driven by national or regional guidance and/or patient safety alerts, or through analysis of internal processes.
Medicines Management Nurses	To educate and support staff across the organisation in both medicines' management/optimisation and in response to any medication incidents and learning.
All staff involved with the use of medicines	All staff remain responsible and accountable in their practice, ensuring they work in accordance with all guidance around the safe and secure handling, storage, prescribing, ordering, administration, and disposal of medications and bring to the attention of their manager any issues that prevent this.
Nursing Students	Whilst on placement in a clinical area all Pre-Registration students Nurses and Trainee Nursing Associates are responsible for their

	actions and omissions and must have a named Registered Practice Supervisor. All incidents involving nursing students must be reported to Trust professional Nursing and Development team and relevant Practice Placement Facilitator (PPF) in conjunction with the students Learning Institution (LI)

6 Guidance

All medication related incidents, at any stage in the medication process, must be reported in accordance with Trust policy and an incident form must be completed. There is a guide to the categories to use in reporting medicine incidents on InPhase . This can be found in the pharmacy, medication safety pages on the Trust intranet download.cfm (tewv.nhs.uk)

Following any medicines incident please refer to the process flowchart for supporting staff involved in medicine related incidents (Appendix 2). It is important to understand the contributory factors of the incident, whilst keeping an emphasis on support Confidentiality should be maintained where appropriate, whilst considering the best way to share learning.

If unclear Line managers should seek involvement from the medication safety team – which comprises, medication safety officer, lead pharmacy technician for medication safety and medicines management nurses.

Response to incidents should be proportionate. Staff should reflect on the incident, complete the reflection form (appendix 3), and use the reflection to discuss the incident with the line manager.

Medicine incidents should be reviewed in a timely manner. There is an optional Investigation Tool for Medication Incidents (appendix 4) which can be used as part of a reflective discussion within management supervision/ 1:1 discussion.

If at any time during the medicine incident investigation safeguarding concerns arise, they must be managed in accordance with current Safeguarding Adults Policy and the Safeguarding Children Policy.

If during an investigation procedural matter relating to professional standards, conduct and performance are identified, the investigating team must refer these matters to the relevant head of service and/or professional lead.

If there are concerns that a criminal act has taken place then the scene of the incident must be secured and preserved, all investigations should stop. The relevant head of service and, if agreed, the police should be notified immediately.

7 Definitions

Term	Definition
Clinical incident	• An adverse health care event or omission arising during clinical care and causing physical or psychological harm to a patient.
Medicine incident	• Any incident where there has been an error in the process of prescribing, transcribing, ordering, dispensing, preparing, administering, monitoring, or providing medicines advice, regardless of whether any harm occurred or was possible.
No harm	• A medication incident did not cause any physical harm.; an event or situation that could have resulted in an incident but through timely intervention or good fortune did not reach the patient. Reporting provides valuable insight into where systems need to be improved to prevent death or serious harm. They are important as patients with different susceptibilities may suffer harm from the same incident.
Low harm	• Minimal harm occurred - patient or staff required extra observation or minor treatment. • Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. • Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication. • Did not or is unlikely to affect the patient's independence • Did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate harm	When at least one of the following apply: • Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency. • Department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate lifesaving intervention. • Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm. • Can include RIDDOR reportable incidents.
Severe harm	When at least one of the following apply: • Permanent harm • Needed immediate life-saving clinical intervention. • Is likely to have reduced the patient's life expectancy. • Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment.

	• Has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions. • Can include RIDDOR reportable incidents.
Fatal	Previously documented as 'Death' in NRLS – record as an outcome. Unexpected death - The death of a patient because of a patient safety incident. Report as a patient safety incident.

8 How this procedure will be implemented

- This procedure will be published on the Trust's intranet site.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

8.1 Training needs analysis

See Medicines Overarching Framework

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).
1	Analysis of medication incidents	Medication Safety Team	Pharmacy medication safety and governance group Medicines management group

10 References

NHS England Policy guidance on recording patient safety events and levels of harm
NHS England Patient Safety Incident Response Framework
Implementing a systematic response to medication errors - PubMed (nih.gov)
NPSA (2009) Safety in Doses
NHS England » A just culture guide
Standards and guidance for pharmacy professionals | General Pharmaceutical Council (pharmacyregulation.org)

Rolfe et al.'s (2001) reflective model
Incident reporting and serious incident review policy,
Managing concerns of potential conduct (Disciplinary) Procedure
Managing Concerns of Potential Poor Performance (Capability) Procedure
Safe and secure handling of medicines | RPS (rpharms.com)
Professional Guidance on the Administration of Medicines in Healthcare Settings January 2019
Advisory guidance - administration of medicines by nursing associates.pdf (hee.nhs.uk)
NHS England » The NHS Patient Safety Strategy
Health and Social Care Act 2008 (Regulated Activities) regulations 2014: Regulation 20. Duty of Candour
HSSIB Support for staff following patient safety incidents (hssib.org.uk) January 2021

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

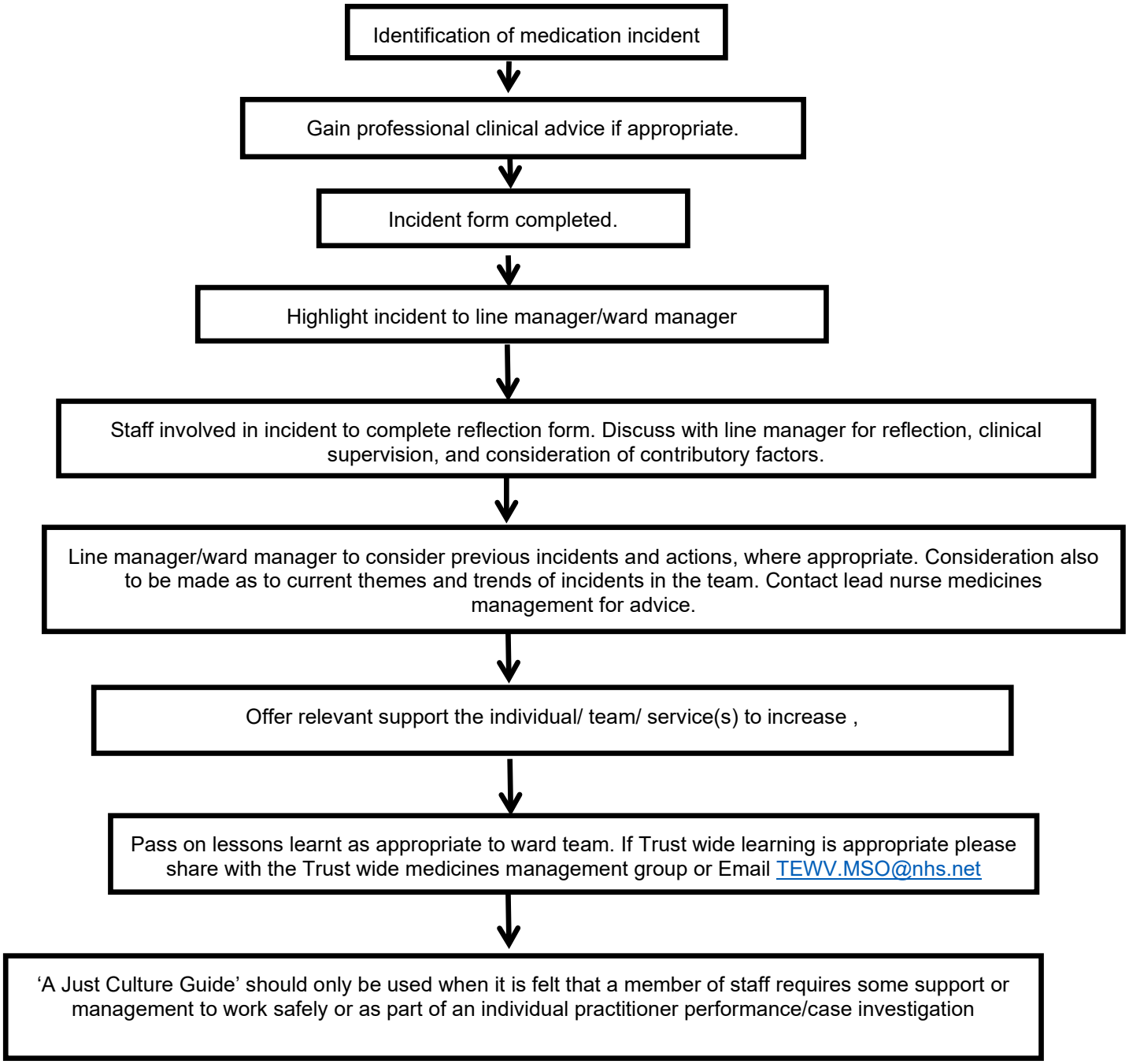
Required information type	Information
Date of approval	25 July 2024
Next review date	01 July 2027
This document replaces	Supporting Staff and Learning from Medication Incidents V3
This document was approved by	Drug & Therapeutics Committee
This document was approved	25 July 2024
This document was ratified by	N/A
This document was ratified	N/A
An equality analysis was completed on this policy on	Generic Pharmacy Equality analysis applies
Document type	Public

Change record

Version	Date	Amendment details	Status
2	26 Jan 2017	Full revision	Superseded
	09 Jan 2020	Review date extended to 01 Apr 2020	Superseded
3	June 2021	Full review. Just culture guide added. Junior Dr flowchart added. Pharmacy error section added.	Superseded

		Appendix 3 removed. Appendix 2 reviewed. Document title amended.	
4	25th July, 2024	Full review Streamlined. Reviewed to be more in line with PSIRF principles. Removed some of the pharmacy specific processes, which will form separate internal pharmacy guidance.	Published

Appendix 1 - Process Flowchart



Further information and support should be obtained from the Lead Medicines Management Nurse or Medication Safety Officer: linda.johnstone4@nhs.net or TEWV.MSO@nhs.net

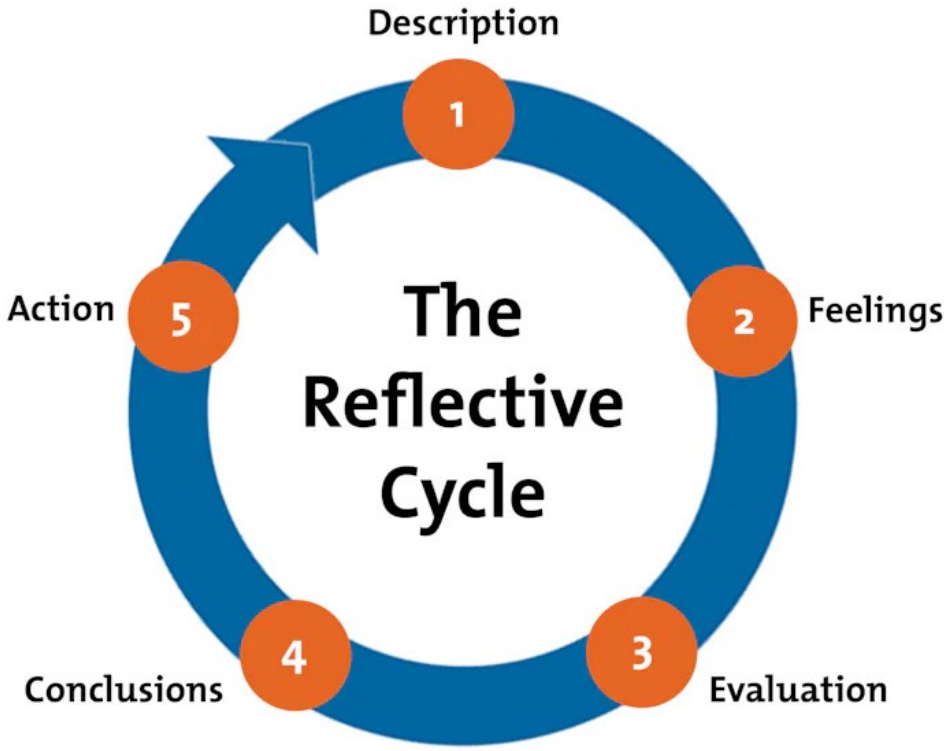
Appendix 2 - Medication Incident Reflective Form

When completing your reflection consider:

- Describe the event (time of occurrence, venue, medication/s involved, presentation of the patient, the nature of the error, any other staff involved etc.)
- Please reflect on your actual practice when the medication incident occurred (try to recall what you did on that day. Why did I act as I did? How does this differ from my normal practice? What internal/external factors may have influenced my actions?)
- Please reflect on the environment on the ward or in the department at the time the incident occurred (were you required to respond to interruptions, how many staff were on duty, what was their skill mix, how many shifts since your last day off, were any other patient safety incidents occurring at the same time, did any patients require a high degree of attention or observation, was it busy / chaotic?)
- Did you have all the information you required to hand to complete the task (specific drug information, all relevant patient information, a clear legible prescription etc?)
- Do you experience any difficulties in accessing and implementing Trust policies, procedures, and protocols in relation to medicines management? Did this play a part in the incident?
- What would you have done differently, what have you learnt from this incident for yourself and for your team?

Gibbs' Reflective Cycle (Gibbs 1988)

The Gibbs' reflective cycle is a continuous cycle of improvement tool used for self-reflection and helps to learn from the experience.



Incident ID……

It is important to reflect and review an incident so that everyone involved, and the wider Trust can learn from what has occurred and improve patient safety in the future. Please reflect on the incident as soon as possible, ideally within seven days of the incident occurring.

This document can be used to reflect on the incident with your line manager. It should be retained in a portfolio or CPD record and presented at annual appraisal or submitted as part of the revalidation or portfolio review process as appropriate. Note: As a professional you may wish to reflect on this incident for part of your revalidation using the professional bodies paperwork.

Staff Memory Capture Form

This form *is a template to help staff to recall the events of an incident as they remember them*

What is required?

You may find it helpful to write your memory capture in two parts:

1. ***What I can recall about the care and treatment I was giving to the patient, before, during and after the incident***
2. ***What I can recall of the shift – No patient receives their care in a vacuum. There are always other activities going on. It is important that 'this incident' is considered with a good understanding of what else was happening***

Staff Name:	**Job title:**
Date of incident :	**Date of Memory Capture:**

Memory Capture Details:

Confidentiality: ***It is important to understand that this document, as with all statements and reflective diaries are disposable ad can be requested by the coroner and representatives of the patient. This should not deter you from giving a complete account of your involvement in the patient management or your experience of the environment, team working etc on the day. It should however remind you to write correctly so that what you write is not misinterpreted or misconstrued.***

Trust Pharmacy Team Framework for Reflection

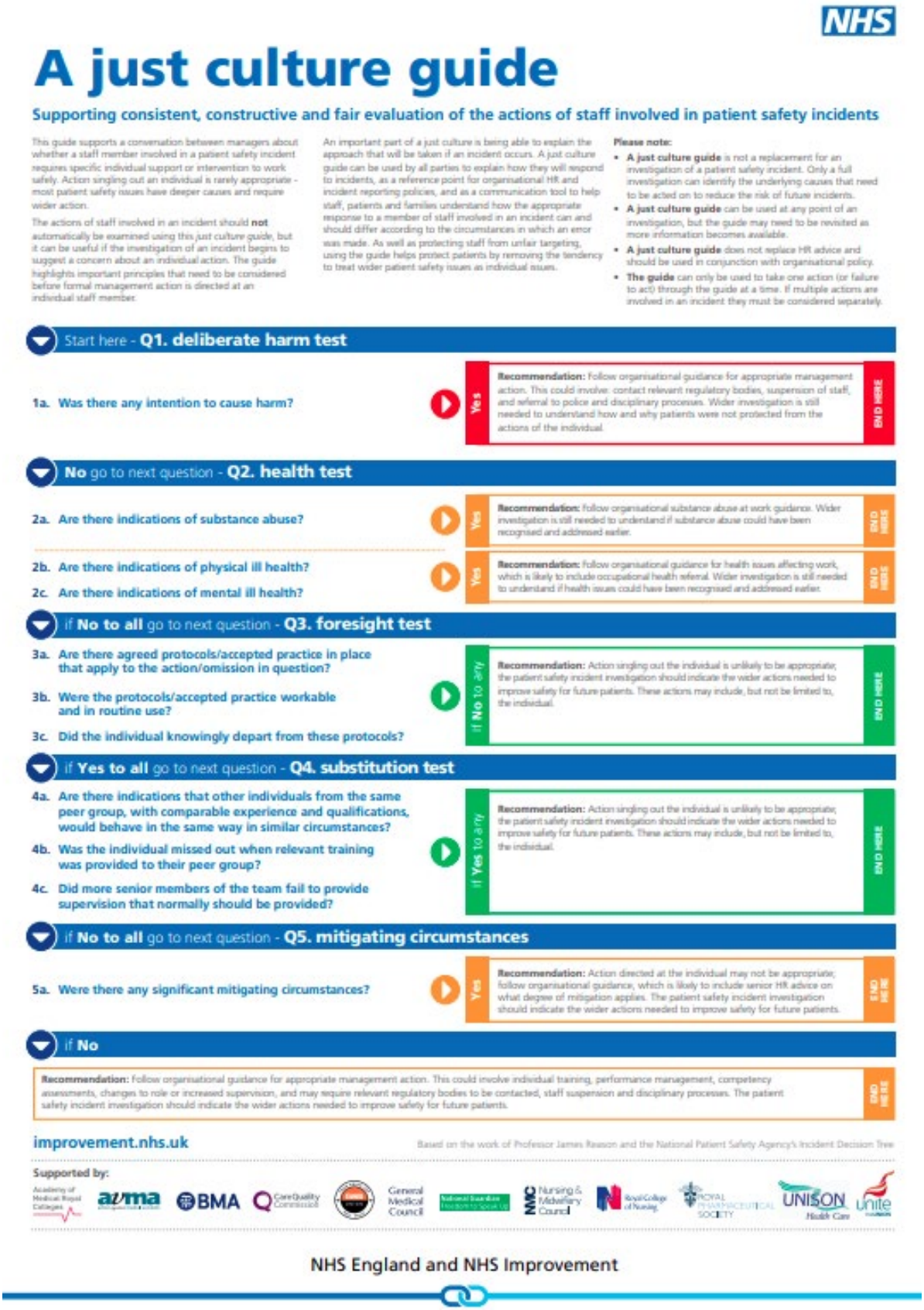
Name:…… **Date:……..**

What? ***(Identify the experience & describe it in detail)***	***Prompts:*** *What is the issue, problem, difficulty, scenario? What was my role in the situation? What was I trying to achieve? What action did I take? What was the response of others? What were the consequences e.g. for the patient, for me, for others? What feelings did it invoke in the patient, me, others? What was good or bad about the experience?*
So what? ***(Analyse & evaluate the situation to draw conclusions)***	***Prompts:*** *Does this tell me/teach me/imply/mean about: me, my patient, others, my attitudes? What was going through my mind as I acted? What did I base my actions on? What additional knowledge can I bring to the situation? What could I/should I have done to make it better? What is my understanding of the situation? What broader issues arise from the situation?*
Now what? ***(Explore alternatives & planning action that will be put into practice)***	***Prompts:*** *What do I need to do to e.g. make things better, stop being stuck, improve my patient's care, resolve the situation, feel better etc. What broader issues need to be considered if this action is to be successful? What might be the consequences of this action? Are there any lessons learnt that could be shared?*

For reflections on errors/incidents only, date discussed with Line Manager

Appendix 3 – A just culture guide

This can be accessed from the link here



NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

If **No** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

If **Yes** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. **Were there any significant mitigating circumstances?**

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

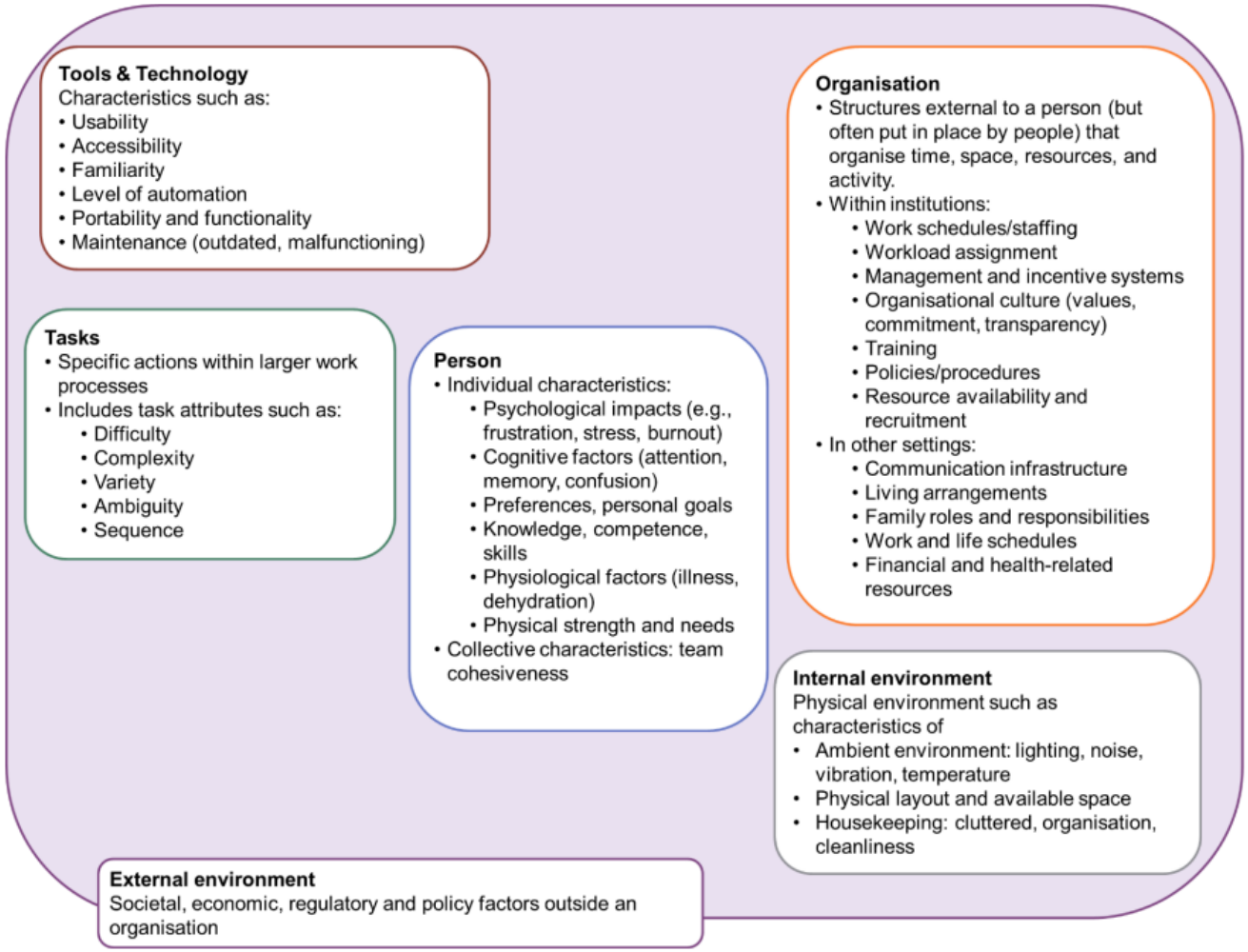
Appendix 4 - Optional Investigation Tool for Medication Incidents

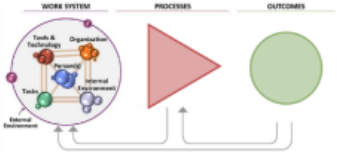
SEIPS (System Engineering Initiative for Patient Safety) framework tool

Trustwide tool which may be utilised to look at the interactions between different aspects which may have contributed to an event occurring.

(please see over page)

Overview of SEIPS





Desired Outcomes

System Performance:

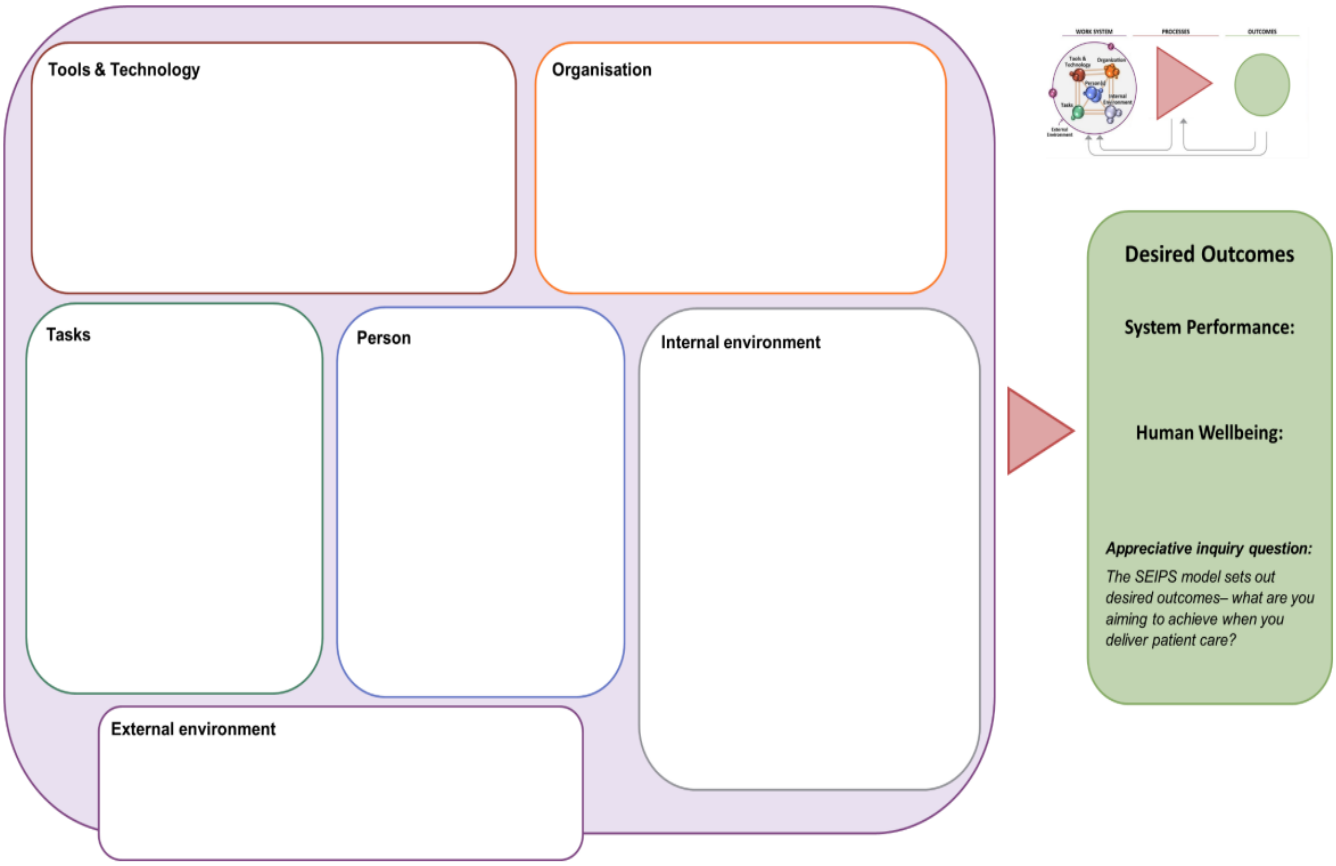
Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

SEIPS template

Copies can be obtained from- Patient Safety Incident Response Framework (PSIRF) | TEWV Intranet



The following appendices include guidance for Pharmacy staff and Junior Doctors

Appendix 5 - Junior Doctors Involved with Medication Incidents or Errors Flowchart

Monthly basis

Information Analyst provides Medical Education Manager with a report detailing any incidents which have been linked to Junior Doctors

↓

Within 1 week of receiving report

Medical Education Manager filters the report into localities and adds an additional column to the report to detail the name of the junior doctors Clinical Supervisor

↓

Within 1 week of receiving report

The Medical Education Manager provides the Associate Director of Medical Education (ADME) with a copy of the report for their localities

↓

Within 2 weeks of receiving locality report

ADME reviews the incident report and decides whether the junior doctor's Clinical Supervisor (CS) needs to be made aware of the prescribing incident or error dependent upon the level of the incident which has been reported

↓

Incident requires escalation to CS

ADME contacts CS and requests that the incident / error is discussed at the next formal supervision meeting with the junior doctor. ADME will document in the action plan the agreed steps with the CS and junior doctor and return the completed action plan template to the Revalidation

Incident does not require escalation to CS

ADME completes action plan stating that no further action is required, and returns completed action plan template to the Revalidation Advisor (TEWV)

↓

Incident requires discussion in supervision

CS and junior doctor discuss the incident / error. Junior Doctor will complete a written reflection and enter onto ePortfolio which is reviewed by a panel during ARCP

Appendix 6 - Pharmacy staff involved in medication incidents.

What is an error?

- Any dispensing error that leaves the dispensary
- A dispensing error that is picked up before it leaves the department (known as a near miss error)
- A clinical error on the ward for example: - incorrect medicine reconciliation, transcribing error
- An operational error for example: - wrong medication ordered for a patient.

Definitions

Role	Definition
Dispenser	Pharmacy assistant, pharmacy technician, pharmacist who dispense medication in a pharmacy dispensary/ward
Clinical pre screen	Pharmacist who pre-screens prescriptions/orders for clinical and legal accuracy
Final accuracy checking	Accredited accuracy checking pharmacy technician or pharmacist who checks dispensed items before they leave the dispensary

Appendix 7 - Management of Dispensing Errors

Medication has left the dispensary

Medication left the dispensary

Confidentiality must be maintained

Dispensing error picked up by ward staff/patient – incident form to be completed within 24 hours of finding the error.

Locality lead pharmacy technician/pharmacist to be informed.

Locality lead technician to obtain all relevant documents including emis information, original prescription/order.

Staff involved in the error, to complete medicines incident reflection form. No later than one week after the incident was reported.

Line manager to review error and reflection form with individual.

Copy of the refection to be added to personal file.
Learning and actions to be noted on the pharmacy incident spreadsheet.

Incident form to be reviewed. Check there is no person/location identifiable information in the description boxes. Review level of harm. Add in any missing information such as ward details. Complete learning response section. Please aim to review within seven days.

Note – if medication is involved in any error. This must be given to the locality lead technician and not returned to stock/disposed of.

Copy to be placed in personal file.
Learning and actions to be noted on the actions and learning tab on the near miss spreadsheet

Pharmacy Clinical or Operational Errors

Error found on ward where pharmacy may have involvement.

Confidentiality must be maintained.

Error picked up by ward or pharmacy staff – incident form to be completed within 24 hours of finding the error.

Incident notification to be sent to locality inbox. Locality leadership team to monitor the locality incident email inbox.

Locality lead technician to obtain all relevant documents including emis information, original prescription/order, copy of prescription charts, actual medication if appropriate related to the incident.

Staff involved in the error, to complete medicines incident reflection form.

Line manager to review error and reflection form with individual.

Incident form to be reviewed. Check there is no person/location identifiable information in the description boxes. Review level of harm. Add in any missing information such as ward details. Complete learning response section. Please aim to review within four days.

Copy of the refection to be added to personal file.
Learning and actions to be noted on the pharmacy incident spreadsheet.

Note – if medication is involved in any error. This must be given to the locality lead technician and not returned to stock/disposed of.

Appendix 8 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

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	Been out for consultation No comments received
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?	N/A	
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?	NA	Generic Pharmacy Equality analysis applies
Have Equality and Diversity reviewed and approved the equality analysis?	NA	
9. Approval		
Does the document identify which committee/group will approve it?	YES	
10. Publication		
Has the policy been reviewed for harm?	Yes	
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	