Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Prescribing Audit – Process for Prescribing Medicines PH1609

Division:	C. S. F. M.
Speciality:	Pharmacy
Audit Lead:	Kathleen Ibison
Audit Team:	Sarah Murphy (Pre-registration Pharmacist) Janine Bailey (Medicines Management Support Officer)
Standard:	CORP/PROC/301/CQC Outcome 9
Date:	March 2017
Name of responsible /approving committee:	Medicines Management Committee
Date of committee meeting:	July 2017

1. Introduction

Unclear and incomplete prescriptions are a proven risk to patients. Administering or dispensing against such prescriptions within the National Health Service in the past has led to serious patient injury and consequential litigation and professional disciplinary action taken against the Trust and health professionals involved in all stages of the medication process.

The General Medical Council (GMC) states that all doctors must keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment.

The Nursing and Midwifery Council (NMC) states that registrants must check that the prescription and the label on the medicine dispensed are clearly written and unambiguous.

The Royal Pharmaceutical Society of Great Britain (RPSGB) code of ethics states that pharmacists and pharmacy technicians must take steps to safeguard the well-being of patients and seek to ensure safe and timely access to medicines and take steps to ensure the clinical appropriateness of medicines supplied to individual patients.

Blackpool Teaching Hospitals NHS Foundation Trust Pharmacy Department is committed to continuously ensuring the “Accuracy of prescription charts” within all clinical areas and that standards are monitored and sustained through annual audit, and results are disseminated to Divisional Heads for action.

2. Aim/Objectives

This audit aims to evaluate, support and promote good practice in prescription writing in order to minimise the risk to patients from poor prescription writing by specifying a minimum level of acceptable practice and the steps that must be taken when this level is not met.

The audit was designed by the Pharmacy Department and will be undertaken within the divisions by appropriately nominated staff on an annual basis. All results will then be presented at the next Medicines Management Committee meeting. All results for the Trust will be analysed by pharmacy and will then be disseminated to all Clinical Directors, ADOPs, Head Nurses and Matrons for discussion at individual divisional meetings.

Each division must complete an acknowledgement receipt of the audit results, and confirm that an action plan that has been initiated following discussion of the results at the divisional meeting. (This response is required before the

next Medicines Management Committee meeting which is normally 2 months from the issue date.) Divisions that fail to respond or acknowledge the audit will be followed up by the Director of Pharmacy on behalf of the Medicines Management Committee.

The accuracy of prescription charts audit will be included on the Medicines Management Rolling Audit Programme and be undertaken annually, to ensure that standards are monitored and continuously improved.

References

1. General Medical Council. Good Medical Practice (2013).
2. Nursing & Midwifery Council. Standards for Medicines Management (2008).
3. Royal Pharmaceutical Society of Great Britain. Medicines, Ethics and Practice (MEP) 38 (July 2014).

3. Standards

See CORP/PROC/301 Prescribing – A Zero Tolerance Approach to Safe Prescribing.

PROCEDURE

The Responsibility of Prescribers
The prescription chart will eventually form part of the patient's notes and as such is a legal document admissible in court. Prescriptions must meet the minimum prescribing standards stipulated. Prescribers will be asked to rewrite or complete any prescription entry that does not fulfil the minimum requirements which may result in a delay to patients receiving medication.

Minimum acceptable standards for accurate prescription writing

- All prescriptions to be written in indelible black ink.
- All items on the prescription must be printed in clear & legible handwriting.
- All items must be signed.
- All items must include a legible printed name next to the signature.
- All items must include a personal bleep number (when available), not a baton bleep.
- All items must have a start date.
- All items must have times of administration clearly stated.
- All antibiotic items must be written on the Antibiotic Section. The times written as a 24 hour clock e.g. TDS as 0600, 1400, 2000.
- All items requiring changes to drug/dose/frequency must be written as a new prescription entry and the previous entry must be crossed off. Do not amend existing prescriptions – start again.

- All drug cancellations must be made with a clear bold line across the drug name and administration sections (without obliterating the patient record).
- All cancelled items must have a stop date. The date of cancellation should be entered in the stop-date box. When the 'stop-date' box is used in anticipation of the treatment cancellation date, this indicates that from midnight on the specified date, the prescription must be discontinued and no further doses are to be administered. A line should be drawn through the administration section to indicate that the prescription should not be given past that date.
- All cancelled items must have a signature.
- All drugs must be prescribed by their generic names, unless brand name prescribing recommended by the BNF. Common examples are Beclomethasone inhalers, Theophylline, Diltiazem, Nifedipine, Lithium, Mesalazine modified-release preparations.
- All drug names must be written in full.
- All items must include the frequency of administration.
- All 'additional information' must be clear and unambiguous.
- Drug administration device types must be included on the prescription, e.g. inhaler type (MDI, turbohaler, accuhaler) and insulin type (flexpen, kwikpen etc.).
- All prescriptions must include the strength of the preparation (where this is necessary).
- All items must include the dose and dose units (where this is necessary). only these approved dose unit abbreviations may be used:
  - g is accepted for gram
  - mg for milligram
  - micrograms to be written in full
  - nanograms to be written in full
  - 1 gram or more should be written as 1g, 2.4g etc.
  - Less than 1g should be written in milligrams – 250mg and not 0.25g.
  - Less than 1mg should be written in micrograms – 100 micrograms and not 0.1mg
  - Only use decimal points and zeros if necessary e.g. prescribe 3mg and not 3.0mg
  - ml is accepted for millilitres
  - Caution with liquid formulations. Many different strengths of the same drug can exist or are manufactured. It is safest for the prescriber to prescribe as the dose and not volume (except when there is not a strength e.g. lactulose, gaviscon)
  - caution with 'combination' preparations
- The word UNITS must be written in full and not abbreviated to 'U' or 'I.U'.
- All PRN medicines prescribed with a drug interval and maximum daily dose.

Process for Ensuring the Accuracy of All Prescription Charts

- The pharmacist will, on a daily basis (Monday – Friday) visit specific wards as identified on the Pharmacy ward rota.
- The pharmacist will confirm accuracy of the prescription chart by initialling the prescribed drug in green pen (in the box provided).
- The pharmacist will check the prescription chart in relation to the following:

a. Legibility and completeness to avoid misunderstanding or error.
b. Dose and frequency of each drug.
c. Drug incompatibilities.
d. Route of administration.
e. Duration of treatment.
f. Suitability of the drug for individual patients.
g. Generic names are prescribed (unless Trade name prescribing is indicated).

- The pharmacist will annotate correct prescription charts with green pen in the pharmacy box on the prescription chart.

Accurate Completion of In-Patient Prescription Chart

- The in-patient medication prescription chart must make reference to any separate charts on which drugs have been prescribed.
- Only one current prescription chart of each relevant type should exist at any one time for any patient. However, is complete then a second chart may be used. The first prescription chart must be marked chart '1 of 2' and the second prescription chart '2 of 2'.
- Multiple prescriptions must be kept together.
- Prescriptions should be kept at the end of the bed or in a prescription folder.
- The use of Continuation Sheets (to extend the administration section) on inpatient medication charts is not approved at Blackpool Teaching Hospitals NHS Foundation Trust.
- When all the 'date columns' are completed, the prescription chart must be rewritten.
- Completed or cancelled prescription sheets must be made obsolete by making a diagonal line (without obliterating the patient record) across the chart and filed in the patient's case notes as a permanent record.
- If a patient is re-admitted, including for respite care, a new prescription chart must be written.
- When patients are transferred from other Trusts, a new prescription must be written.

Patient Information

- Patient must be a registered hospital patient.
- Patient's full name (including aliases).
- Date of birth or age.
- Consultant's name.

- Ward or clinic name.
- Unit number or other identifier.
- Patients address.
- Gender (if blood product).
- Weight.
- Height.
- GP.
- Hospital.
- Date of admission.

Handwriting

- All prescriptions to be written in indelible black ink.
- All items on the prescription must be printed in clear & legible handwriting.

Prescriber's Identity

- All items must be signed.
- The signature must be legible or include a legible printed name next to the signature.
- All items must include a personal bleep number (when available). Not a baton bleep.

Date

- All items must have a start date.
- When a prescription is re-written, the 'start date' must be the original start date and not the date of the re-write.

Frequency of Administration

- All items must have times of administration to be clearly stated.
- All antibiotic items must be written on the Antibiotic Section. The times written as a 24 hour clock e.g. TDS as 0600, 1400, 2000.

Name of Drug

- Full drug name must be prescribed.
- Abbreviations for drug names are not acceptable.
- Obsolete Latin abbreviations should be used.
- Prescribe using non-proprietary (trade) name should be used are:
  - Drugs with a narrow therapeutic margin, where there are brand differences e.g. lithium, theophylline, ciclosporin, mesalazine.
  - Where the BNF recommends prescribing drugs by brand name because they are modified release e.g. nifedipine, diltiazem.
  - If there is potential for confusion e.g. erythropoietin, tacrolimus.
  - Combinations of drugs where there is no generic name e.g. oral contraceptives.

How to change a prescription

All items requiring changes to drug/dose/frequency must be written as a new prescription entry and the previous entry must be crossed off. Do not amend existing prescriptions. All drug cancellations must be made with a clear bold line across the drug name and administration sections (without obliterating the patient record).

All cancelled items must have a stop date. The date of cancellation should be entered in the stop-date box. When the 'stop date' box is used in anticipation of the treatment cancellation date, this indicates that from midnight on the date specified, the prescription must be discontinued and no further doses are to be administered. A line should be drawn through the administration section to indicate that the prescription should not be given past that date. All cancelled items must have a signature.

Drug Allergies – Sensitivities

The admitting nurse or doctor should determine if the patient has any known allergies. Known allergies may be confirmed by asking the patient, next of kin, General Practitioner or referring to the medical notes. Nurses and other practitioners should assist in identifying medicine sensitivities during patient consultations.

The prescriber is responsible for recording the known drug allergies or no known drug allergies (NKDA). The allergies must be documented in the allergy box provided on all hospital charts used for prescribing, dispensing or administration, and in the medical and nursing notes.

4. Methodology

During a visit to the wards ten prescription charts were chosen at random to be audited during February and March 2017 using the proforma (appendix 1) the decision was made to only audit the regular items which had been prescribed. Therefore, for each chart there was a possible ten items audited.

The audit proforma was designed using the required standards within the Trust policy CORP/PROC/301 – Prescribing Medicines – A Zero Tolerance Approach to Safe Prescribing. All prescribers must fully comply with these standards.

5. Results / Findings

A total of **407 prescriptions** were audited containing **2650 items**. The results are split into Families, Cardiac, ALTC, Scheduled Care and Unscheduled Care Divisions.

- ALTC – **30 prescriptions, 228 items**
- Cardiac – **57 prescriptions, 439 items**
- Families – **31 prescriptions, 78 items**
- Scheduled Care – **90 prescriptions, 545 items**.
- Unscheduled Care – **181 prescriptions, 1256 items**.

The results of the audit are presented as per Division below.

Key:

Compliant –

Non-compliant –

	Divisions				
	ALTC	Cardiac	Families	Scheduled Care	Unscheduled Care
Is the patient identifier present?	100%	100%	100%	100%	100%
Is the patients' allergy status present?	71.86%	94.62%	93.75%	99.05%	99.32%
Are all items written in indelible ink?	100%	95.96%	100%	100%	99.32%
Are all items printed in clear and legible hand writing?	83.12%	97.76%	100%	97.64%	98.03%
Are all prescription items signed?	100%	99.55	100%	97.64%	97.82%
Do all items a legible printed name next to the signature?	19.48%	25.78%	70%	34.75%	42.72%
Do all items have a start date?	96.97%	95.74%	96.25%	98.35%	97.01%
Do all items have times of administration clearly stated?	99.57%	99.55%	98.75%	100%	98.1%
Are all items requiring changes to drug/dose/	96.1%	93.5%	90%	95.98%	96.87%

frequency written as a new prescription entry and the previous entry crossed off?					
Have all drug cancellations been made with a clear bold line across the drug name and administration sections (without obliterating the patient record)?	92.21%	89.24%	82.50%	93.62%	93.95%
Do all cancelled items have a stop date?	85.71%	75.11%	71.25%	86.52%	81.43%
If the 'stop date' box has been used in anticipation of the treatment cancellation date, has a line been drawn through the administration section to indicate that the prescription should not be given past that date?	97.84%	100%	100%	100%	99.93%
Do all cancelled items have a signature?	87.88%	84.75%	88.75%	87.94%	86.46%
Are all drugs prescribed by their generic names, unless brand name prescribing is recommended by the BNF? For example, beclomethasone inhalers, theophylline,	98.7%	95.07%	95%	93.85%	94.76%

diltiazem, nifedipine, lithium and mesalazine modified-release preparations.					
Are all drug names written in full?	96.97%	97.09%	95%	99.53%	98.16%
Do all items include the frequency of administration?	100%	99.55%	100%	99.76%	100%
Is all 'additional information' clear and unambiguous?	99.13%	99.78%	100%	99.76%	99.59%
Are all drug administration devices included on the prescription? For example, inhaler type (MDI, Turbohaler, Accuhaler) and insulin type (Flexpen, Kwikpen etc.).	98.7%	98.43%	100%	96.93%	96.67%
Do all items include a dose?	98.27%	95.29%	100%	94.8%	93.13%
Do all items include the dose units (where necessary)? For example, micrograms to be written in full.	82.25%	89.46%	93.75%	89.36%	91.5%

RAG Rating

ALTC Division

There is no data available for ALTC as in previous years this division has not been audited.

Cardiac

There is no data available for Cardiac as in previous years this division has not been audited.

Families

Questions	2014	2015	2017	RAG
Is the patient identifier present?	N/A	N/A	100%	↑
Is the patients' allergy status present?	100%	100%	93.75%	↓
Are all items written in indelible ink?	100%	100%	100%	↑
Are all items printed in clear and legible hand writing?	100%	98%	100%	↑
Are all prescription items signed?	100%	100%	100%	↑
Do all items a legible printed name next to the signature?	58%	60%	70%	↑
Do all items have a start date?	80%	100%	96.25%	↓
Do all items have times of administration clearly stated?	100%	93%	98.75%	↑
Are all items requiring changes to drug/dose/ frequency written as a new prescription entry and the previous entry crossed off?	100%	100%	90%	↓
Have all drug cancellations been made with a clear bold line across the drug name and administration sections (without obliterating the patient record)?	100%	44%	82.50%	↑
Do all cancelled items have a stop date?	0%	0%	71.25%	↑
If the 'stop date' box has been used in anticipation of the treatment cancellation date, has a line been drawn through the administration section to indicate that the prescription should not be given past that date?	N/A	N/A	100%	↑
Do all cancelled items have a signature?	38%	6%	88.75%	↑
Are all drugs prescribed by their generic names, unless brand name prescribing is recommended by the BNF? For example, beclomethasone inhalers, theophylline, diltiazem, nifedipine, lithium and mesalazine modified-release preparations.	93%	100%	95%	↓
Are all drug names written in full?	97%	96%	95%	↓
Do all items include the frequency of administration?	N/A	N/A	100%	↑
Is all 'additional information' clear and unambiguous?	N/A	N/A	100%	↑

Are all drug administration devices included on the prescription? For example, inhaler type (MDI, Turbohaler, Accuhaler) and insulin type (Flexpen, Kwikpen etc.).	N/A	N/A	100%	↑
Do all items include a dose?	N/A	N/A	100%	↑
Do all items include the dose units (where necessary)? For example, micrograms to be written in full.	94%	89%	93.75%	↑
Average	**82.9%**	**77.57%**	**89.25%**	↑

Scheduled Care

Questions	2014	2015	2017	RAG
Is the patient identifier present?	N/A	N/A	100%	↑
Is the patients' allergy status present?	98%	97%	99.05%	↑
Are all items written in indelible ink?	97%	94%	100%	↑
Are all items printed in clear and legible hand writing?	86%	91%	97.64%	↑
Are all prescription items signed?	99%	97%	97.64%	↑
Do all items a legible printed name next to the signature?	39%	43%	34.75%	↓
Do all items have a start date?	84%	90%	98.35%	↑
Do all items have times of administration clearly stated?	95%	92%	100%	↑
Are all items requiring changes to drug/dose/ frequency written as a new prescription entry and the previous entry crossed off?	88%	15%	95.98%	↑
Have all drug cancellations been made with a clear bold line across the drug name and administration sections (without obliterating the patient record)?	94%	71%	93.62%	↑
Do all cancelled items have a stop date?	9%	20%	86.52%	↑
If the 'stop date' box has been used in anticipation of the treatment cancellation date, has a line been drawn through the administration section to indicate that the prescription should not be given past that date?	N/A	N/A	100%	↑
Do all cancelled items have a signature?	19%	33%	87.94%	↑
Are all drugs prescribed by their generic names, unless brand name prescribing is recommended by the BNF? For example, beclomethasone inhalers, theophylline, diltiazem, nifedipine, lithium and mesalazine modified-release preparations.	90%	93%	93.85%	↑
Are all drug names written in full?	89%	87%	99.53%	↑

Do all items include the frequency of administration?	N/A	N/A	99.76%	↑
Is all 'additional information' clear and unambiguous?	N/A	N/A	99.76%	↑
Are all drug administration devices included on the prescription? For example, inhaler type (MDI, Turbohaler, Accuhaler) and insulin type (Flexpen, Kwikpen etc.).	N/A	N/A	96.93%	↑
Do all items include a dose?	N/A	N/A	94.8%	↑
Do all items include the dose units (where necessary)? For example, micrograms to be written in full.	87%	84%	89.36%	↑
Average:	**76.7%**	**71.9%**	**93.3%**	↑

Unscheduled Care

Questions	**2014**	**2015**	**2017**	**RAG**
Is the patient identifier present?	N/A	N/A	100%	↑
Is the patients' allergy status present?	97%	97%	99.32%	↑
Are all items written in indelible ink?	99%	98%	99.32%	↑
Are all items printed in clear and legible hand writing?	90%	96%	98.03%	↑
Are all prescription items signed?	98%	98%	97.82%	↓
Do all items a legible printed name next to the signature?	36%	39%	42.72%	↑
Do all items have a start date?	89%	92%	97.01%	↑
Do all items have times of administration clearly stated?	97%	94%	98.1%	↑
Are all items requiring changes to drug/dose/ frequency written as a new prescription entry and the previous entry crossed off?	79%	86%	96.87%	↑
Have all drug cancellations been made with a clear bold line across the drug name and administration sections (without obliterating the patient record)?	79%	86%	93.95%	↑
Do all cancelled items have a stop date?	3%	7%	81.43%	↑
If the 'stop date' box has been used in anticipation of the treatment cancellation date, has a line been drawn through the administration section to indicate that the prescription should not be given past that date?	N/A	N/A	99.93%	↑
Do all cancelled items have a signature?	15%	27%	86.46%	↑
Are all drugs prescribed by their generic names, unless brand name prescribing is recommended by the BNF? For example, beclomethasone inhalers, theophylline, diltiazem, nifedipine, lithium and	88%	92%	94.76%	↑

mesalazine modified-release preparations.				
Are all drug names written in full?	89%	88%	98.16%	↑
Do all items include the frequency of administration?	N/A	N/A	100%	↑
Is all 'additional information' clear and unambiguous?	N/A	N/A	99.59%	↑
Are all drug administration devices included on the prescription? For example, inhaler type (MDI, Turbohaler, Accuhaler) and insulin type (Flexpen, Kwikpen etc.).	N/A	N/A	96.67%	↑
Do all items include a dose?	N/A	N/A	93.13%	↑
Do all items include the dose units (where necessary)? For example, micrograms to be written in full.	80%	71%	91.5%	↑
Average:	**74.2%**	**76.5%**	**93.2%**	↑

6. Summary

The results found some strong similarities between the divisions.

Each item on the questionnaire is expected to attain 100%.

The standard that achieved Average Full Compliance across all divisions was:

- Is the patient identifier present? This should include any of the following: patient's name, hospital/NHS number, date of birth; address.

The standards that almost achieved Average Full Compliance with a percentage of 85-99% were:

- Is the patients' allergy status present?
- Are all items written in indelible ink?
- Are all items printed in clear and legible hand writing?
- Are all prescription items signed?
- Do all items have a start date?
- Do all items have times of administration clearly stated?
- Are all items requiring changes to drug/dose/frequency written as a new prescription entry and the previous entry crossed off?
- Have all drug cancellations been made with a clear bold line across the drug name and administration sections (without obliterating the patient record)?
- If the 'stop date' box has been used in anticipation of the treatment cancellation date, has a line been drawn through the administration section to indicate that the prescription should not be given past that date?
- Do all cancelled items have a signature?
- Are all drugs prescribed by their generic names, unless brand name prescribing is recommended by the BNF? For example, beclomethasone

inhalers, theophylline, diltiazem, nifedipine, lithium and mesalazine modified-release preparations.

- Are all drug names written in full?
- Do all items include the frequency of administration?
- Is all 'additional information' clear and unambiguous?
- Are all drug administration devices included on the prescription? For example, inhaler type (MDI, Turbohaler, Accuhaler) and insulin type (Flexpen, Kwikpen etc.).
- Do all items include a dose?
- Do all items include the dose units (where necessary)? For example, micrograms to be written in full.

The standard that had an Average Full Compliance of 50-85% was:

- Do all cancelled items have a stop date?

The standard that had Average Full Compliance of less than 50% was:

- Do all items a legible printed name next to the signature?

7. Recommendations

To improve the safety of prescribing within the Trust the following recommendations are made:

- The results of the audit demonstrate disparity across the Trust in the adherence to policy and procedures in relation to safer prescribing practice.
- All Division Heads discuss the identified issues within Teams, and monitor internally.
- Education and training, to improve the knowledge of safe prescribing practice is developed for all prescribers. This is to include FY1 & FY2 doctors and all Non-Medical Prescribers.
- Poor practice is identified and challenged.
- Incidents involving poor prescribing practice are reported through appropriate reporting mechanisms (Untoward Incident Reporting).
- Incidents and near misses involving prescribing are shared across the Trust to ensure learning from experiences are maximised.
- The "Ensuring the accuracy of prescribing audit" is repeated annually to monitor compliance and assess improvements.
- The results are published to all divisions to ensure standardisation and equity in the accuracy of prescribing practice.

Appendix 1

Audit Proforma

		Item No.									
Question No.		1	2	3	4	5	6	7	8	9	10
1	All prescriptions to be written in indelible black ink.										
2	All items on the prescription must be printed in clear & legible handwriting.										
3	All items must be signed.										
4	All items must include a legible printed name next to the signature.										
5	All items must have a start date.										
6	All items must have times of administration to be clearly stated.										
7	All items requiring changes to drug/dose/frequency must be written as a new prescription entry and the previous entry must be crossed off. Do not amend existing prescriptions- start again.										
8	All drugs cancellations must be made with a clear bold line across the drug name and administration sections (without obliterating the patient record).										
9	All cancelled items must have a stop date.										
10	When the 'stop date' box is used in anticipation of the treatment cancellation date, this indicates that from midnight on the date specified, the prescription must be discontinued and										

	no further doses are to be administered. A line should be drawn through the administration section to indicate that the prescription should not be given past that date.										
11	All cancelled items must have a signature.										
12	All drugs must be prescribed by their generic names, unless brand name prescribing recommended by the BNF. Common e,g's are beclomethasone inhalers, theophylline, diltiazem,nifedipine,lithium, mesalazine modified-release preparations.										
13	All drug names must be written in full.										
14	All items must include the frequency of administration.										
15	All "additional information" must be clear and unambiguous.										
16	Drug administration device types must be included on the prescription. E.g. inhaler type (e.g. MDI, turbohaler, accuhaler) and insulin type (Flexpen. Kwipen etc).										
17	All items must include the dose.										
18	All items must include the dose units (where this is necessary). Only these approved dose unit abbreviations may be used:										
	Only these approved dose unit abbreviations may be used: g is accepted for gram mg for milligram										

	micrograms to be written in full nanograms to be written in full 1gram or more should be written as 1g, 2.4g etc Less than 1gram should be written in milligrams. 250mg and not 0.25g Less than 1mg should be written in micrograms. 100micrograms and not 0.1mg Only use decimal points and zeros if necessary e.g. prescribe 3mg and not 3.0 mg ml is accepted for millilitres Caution with liquid formulations. Many different strengths of the same drug can exist or are manufactured. It is safest for the prescriber to prescribe as the dose and not volume. (Except when there is not a strength e.g. lactulose, gaviscon) Caution with “combination” preparations	

Appendix 2

Action Plan

Division: C. S. F. M. **Speciality: Pharmacy**

Audit Date: March 2017

No	Recommendation	Action Required/Comments	Person Responsible	Timescale	Progress	Date Completed	RAG
1	Results and report presented to Medicines Management Committee	Presentation of results and report for discussion at Medicines Management Committee	Medicines Management	21st July 2017	Complete Results also disseminated to Q&G Presented to Scheduled and Unscheduled Care NMPs Presented to Cardiac NMPs	17/08/2017 24/05/2017 10/05/2017 30/08/2017	
2	All results are disseminated to all Divisional Clinical Directors, ADOPs, Head Nurses and Matrons	AG/MM to disseminate results to Divisional Clinical Directors, ADOPs, Head Nurses and Matrons	A Gibson Medicines Management	21st July 2017	Complete	08/12/2017	
5	Prescribing Medicines – A zero tolerance approach to safe prescribing policy is reviewed as required to reflect changes in policy and practice	The policy is reviewed to reflect changes in practice or procedure	A Gibson	On-going	Complete	July 2017	

	legislation						
6	Education and training for Drs, Nurses and other AHPs is provided	Education and training into good prescribing principles will be delivered to all prescribers; the accuracy of prescribing will be highlighted	S Khan Medicines Management Specialist Nurse	Rolling Programme	Ongoing		
7	All professionals will be encouraged to challenge poor practice	Staff will be encouraged to report and challenge poor practice through untoward incident reporting	Clinical Leads, Matrons, Ward Managers	Continuous	Continuous		
8	The prescribing audit questions and format to be reviewed	Critically review 2015 audit questions and format with an aim to improving clarity to staff undertaking the audit	Medicines Management Specialist Nurse	December 2017	Complete	October 2017	
9	Re-audit	The Prescribing audit will be repeated annually to monitor improvement and ensure sustainability	Pre-reg Pharmacist	June 2018	Ongoing		

RAG Rated Key

Green	Completed
Amber	Ongoing
Red	Not Completed