DOH802070-0001

Portsmouth Hospitals NHS Trust
Pharmacy Service

PHPSWI??
Revision level Draft
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# Clinical Intervention Escalation Process

This work instruction is issued and controlled by Portsmouth Hospitals Pharmacy Services. Changes may only be authorised by the Pharmacy Services Manager/Head of Purchasing. Authorised originals of this work instruction are controlled documents maintained on the Portsmouth Hospitals Intranet Website.

AUTHORISED ORIGINALS ON THE INTRANET WEBSITE MAY BE USED AS WORKING DOCUMENTS. PRINTED PAPER VERSIONS OF THIS WORK INSTRUCTION MAY BE USED AS WORKING DOCUMENTS BUT ARE CONTROLLED DOCUMENTS ONLY ON THE DAY THEY ARE PRINTED.

Originator:                                                          Date: 19<sup>th</sup> March 2003

Authorised:     Jeff Watling                                  Date: 19<sup>th</sup> March 2003
                Head of Purchasing/Pharmacy Services Manager

Date Printed:  8 April 2003          Date of Last Amendment:

## 1.     Purpose and scope

This Work Instruction provides guidance to pharmacy staff who may identify a clinical problem on which they wish to intervene and are unable to agree a course of action with the prescriber. In particular it will apply when difficulties are encountered more than once and there is potential for potential for risk to one or more patient(s).

## 2.     Responsibility

2.1     The Head of Purchasing/pharmacy services manager is responsible for ensuring that pharmacy staff are supported in complying with this Work Instruction.

2.2     All staff within Portsmouth Hospitals Pharmacy Service will be responsible for ensuring that this work instruction is followed and that requirements for review and amendment are notified to the Departmental Manager.

## 3.     References

3.1     ISO 9001:2000 para 7.2. Customer related process

3.2     Clinical Pharmacy Survival Guide Chapter 13 Prescription Monitoring, edited Code A
        Code A            Code A

3.3     Pharmacist enabling policy Portsmouth Hospitals NHS Trust Approved by Formulary and Medicines Group 1998

3.4     PHPSWI 063D Clinically Screening a Prescription

## 4.     Definitions:

4.1  **PHPS** – Portsmouth Hospitals Pharmacy Service

4.2  **Prescriber** – any registered medical, dental, nursing or other practitioner with approval to prescribe medicines within the Trust. Excludes medical students and nurses, who have not completed training to allow them supplementary prescriber status.(check form of words!!!!!).

4.3  **BNF**- British National Formulary

5.  **Work Instruction**

5.1  Screening inpatient prescriptions should be carried out in accordance with approved guidance provided in PHPSWI 063D and the Clinical Pharmacy Survival Guide (see 3.2 above)

5.2  Potential reasons for intervention

5.2.1  Problems with prescriptions

- legibility
- drug incompatibility
- dose/strength of medicine
- directions incorrect or missing
- formulation

5.2.2  Problems arising for medication review of new patients

- original diagnosis
- patients own medicines (PODs)
- length of use
- strength and dose
- drug incompatibility
- patient compliance
- therapeutic monitoring

5.2.3  Problems/queries from ward staff

- product availability
- advice concerning administration
- recognition of side effects

5.2.4  Monthly audit and monitoring process

- non formulary prescribing
- changes in demand for narcotic drugs, analgesics and sedatives
- non adherence with clinical guidelines
- non adherence to shared care guidelines
- areas of excessive prescribing

5.3  Problems with prescriptions

5.3.1  Any member of pharmacy staff encountering a problem should decide whether they are

capable of dealing with the problem without reference to the prescriber. This may involve:

- changing the prescription in line with PHTs pharmacist enabling policy
- clarifying the prescription or providing additional information
- obtaining supplies of pateints own medcines via relatives etc.

If in doubt the member of staff concerned should consult with a more experienced colleague.

5.3.2 Any member of pharmacy staff encountering a problem should decide whether they are capable of dealing with the prescriber direct or through a more experienced member of pharmacy staff. If in doubt the member of staff concerned should consult with a more experienced colleague.

5.3.3 Before contacting the prescriber the member of pharmacy staff should establish, as far as reasonable, the facts of the situation. As a minimum this should involve:

- checking the facts of the prescription and nature of the problem against guidance in the BNF or other basic texts
- checking details of the patient and any potential abnormalities with their physical state or condition
- for an inpatient requesting confirmation of what was intended from a member of nursing staff, particularly the named nurse for the patient in question

5.3.4 Once satisfied that s/he has the relevant facts the member of pharmacy staff will contact the prescriber. If the problem is likely to be controversial or involves rewriting the prescription the member of pharmacy staff should suggest meeting face to face if practicable.

5.3.5 If the prescriber is successfully contacted and action agreed the member of pharmacy staff should record, initial and date agreed action on prescription and, if appropriate in the patient's medical record.

5.3.6 If the member of pharmacy staff is unable to contact the prescriber alternative support should be sought, either by escalating the query to the next level of medical staff, or agreeing a fail safe course of action with nursing staff. This may involve:

- Proceeding to supply and administer medication with caution, where patient safety in not an issue.
- Amending the prescription to a failsafe state prior to contacting the prescriber
- Refusing to proceed where patient safety is an issue and no obvious alternative is available.

In each case above a note should be made on the patient's medical record, initialled and dated.

5.3.7 The member of pharmacy staff should record the details of any intervention in their intervention monitoring record.

5.3.8 Any member of pharmacy staff failing to reach agreement on a course of action following a query with a prescriber will report the circumstances to their immediate manager and agree a course of action. Senior members of pharmacy staff should not hesitate to contact Consultant Medical Staff in the event of a query involving junior medical staff.

5.3.9 Any member of pharmacy staff experiencing recurring problems with a prescribing by an individual prescriber or an individual prescriber will report the circumstances with their immediate manager and agree a course of action. Senior members of pharmacy staff should not hesitate to contact Consultant Medical Staff in the event of recurring problems with prescribing or an individual prescriber.

5.3.10 Divisional pharmacists or other senior members of pharmacy staff experiencing recurring problems with Consultant Medical Staff or GPs will report the circumstances with their immediate manager or the pharmacy services manager and agree a course of action. Senior members of pharmacy staff including the pharmacy services manager should not hesitate to contact Consultant Medical Staff or GPs in the event of recurring problems with Consultant Medical Staff or GPs

5.3.11 In the event of recurring problems with prescribing by or with Consultant Medical Staff or GPs the pharmacy services manager will report the issue to the Divisional Clinical Director or Medical Director of the Trust concerned and agree a course of action.

5.3.12 Any member of pharmacy staff dealing with an issue as in 5.2.9 to 5.2.11 above will ensure that a record is made of the event(s), agreements and actions taken

5.3.13 Divisional pharmacists will ensure that a system is in place to record, analyse and report trends with regard to clinical interventions. These will be reported three monthly to the pharmacy services manager as part of the management review process.

Portsmouth Hospitals NHS Trust
Development Directorate

# Clinically Screening A Prescription

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Originator_____     Date_____

Authorised_____     Date_____
       **Pharmacy Operations Manager**

Date Printed:                Date of Last Amendment:  29 January 2002

1.    **Purpose and Scope**
      This work instruction describes the processes involved in the Clinical Screening of a Prescription

2.    **Responsibility**

2.1   The Pharmacy Operations Manager is responsible for the content of this Work Instruction.

2.2   All pharmacists working in the dispensary must ensure that a prescription is legal, safe and unambiguous and that all problems related to the prescribed drugs are resolved prior to dispensing.

3.    **References**

      Royal Pharmaceutical Society of Great Britain - Med. Ethics Guide RPSGB
      Endorsing Guidelines - Issued by Portsmouth Hospitals NHS Trust

4.    **Definitions**

      **PHPS** - Portsmouth Hospitals Pharmacy Service
      **WI** - Work Instruction
      **Inpatient Charts** - Prescription form used for inpatients on the wards and repeats
                (Ref:- MR411 or MR411/98A).

TTO's - Prescription for patients to take home when discharged from a ward
(Ref:- MR601 or Discharge Form)
**OPD** - Outpatient department prescription form (Ref:- MR601)
**A&E Prescription** - Accident and Emergency prescription form
(Ref:- WNV 1068 A/E)

## 5.        Procedure

### 5.1        Prescription Types

5.1.1        There are three main types of prescriptions presented for screening:

    i)        Inpatient charts
    ii)        TTO forms
    iii)        OPD forms
    iv)        Offsite unit telephone requests

### 5.2        Inpatient Chart Screening

5.2.1        The pharmacist screening the prescription needs to ensure that:

    a)        The patient's name is present
    b)        The ward shown on the chart and request slip agrees
    c)        The cost centre is clear
    d)        The doctor's writing is legible and that all trade names are generically endorsed
    e)        The drug name is clear, and that the dose, frequency and timing of dose administration are appropriate and drug form e.g. injection, oral or rectal etc. are the most appropriate for that patient
    f)        There are no drug interactions or contradictions
    g)        There are no drugs prescribed that the patient has an allergy to
    h)        Patients age or surface area is included if relevant
    i)        The drug is valid for the patient and condition
    j)        Treatment courses have a stop date if appropriate
    k)        Each drug is examined individually and then the whole chart collectively
    l)        The prescription is signed and dated
    m)        When satisfied with the above and all ambiguities or problems have been resolved the screening pharmacist endorses the chart against each drug request with:

        i)        Their initials
        ii)        The date
        iii)        The quantity to be supplied leaving enough room for the dispenser and checker to add their initials.

5.2.2        Prescription endorsing guidelines should be followed at all times.

## 5.3    TTO Screening

5.3.1    The screening pharmacist checks the drug chart against the drugs written up on the TTO form to ensure the transcription has been completed fully and correctly.

5.3.2    Check points a to 1 on the Inpatient Screening (section 5,2), and that there are no unnecessary prescribed items.

5.3.3    If there are any discrepancies these need to be clarified either by contacting the ward or bleeping the prescriber (see PHPSWI 059D).

5.3.4    Once the screener is satisfied that all the information required to dispense the prescription is present he/she endorses the prescription with their initials in either the right hand margin or the designated check box (depending on the type of TTO form) Endorsement relating to lip closure e.g. CRC or non CRC, label size and additional information required also needs to be made.

5.3.5    Check there is an adequate supply of drugs previously supplied to wards labelled with directions e.g. inhalers and eye drops and re-supply if in doubt and endorse as "supply from ward".

5.3.6    When screening Patient's Own Drugs (POD's) ensure there are adequate quantities for a minimum of 7 days (may need to confirm date of discharge and supply accordingly). However, check:

    i)       No dose changes
    ii)      No frequency changes
    iii)     If medicines have been dispensed in the last six months
    iv)     Medicines are in good condition and not mixed
    v)      Ensure topical preparations are in date e.g. eye drops have not been opened for more than three weeks.

5.3.7    The screener also endorses the drug chart with number of items, date and initials, so informing the ward that the TTO's have been dispensed for that patient on that date.

## 5.4    Outpatient Prescription Screening

5.4.1    The pharmacist screening reads the prescription and checks a to 1 on Inpatient Screening (section 5.2)

5.4.2    After resolving any ambiguities or problems, the pharmacist must endorse the prescription with their initials in the right hand margin.

5.4.3    The prescription can then be dispensed.

# TRUST POLICY AND PROTOCOL FOR PREPARATION, APPROVAL, PUBLISHING, AUDIT AND REVIEW OF CLINICAL GUIDELINES

## CONTENTS LIST:

## APPENDICES:

| | |
|---|---|
| **Originator:** | **Jeff Watling**<br>**Pharmacy Services Manager** |
| **Approval Route:** | **Formulary and Medicines Group**<br>**Area Prescribing Committee**<br>**Executive Membership of Clinical Governance Committee**<br>**Sub-Group of Clinical Governance Committee**<br>**Hospital Management Team** |
| **Issue No:** | **1** |
| **Date of issue:** | **March 2003** |
| **Pilot Completion Date:** | **September 2003** |
| **Review Date:** | **September 2004** |
| **Audit Date:** | **September 2003** |

## 1. ITEM

Policy for the Preparation, Approval, Publishing, Audit and Review of Clinical Guidelines

## 2. POLICY STATEMENT

This document outlines the policy to ensure the consistent preparation, approval, publishing, audit and review of Clinical Guidelines for use within Portsmouth Hospitals NHS Trust and throughout secondary care services within the Portsmouth and South East Hampshire health economy.

## 3. DEFINITION

Clinical Guidelines

Guidance documents prepared to assist clinicians, nurses and pharmacists in the safe control and administration of medicines for specific clinical conditions.

Guideline Project Manager

A member of pharmacy staff designated, by the Pharmacy Services Manager to project manage the process for development of a clinical guideline.

Guideline Development Group

A group established by a Guideline Project Manager to prepare a Clinical Guideline.

## 4. EVIDENCE BASED GUIDELINES/PROTOCOLS/PROCEDURE FOR PRACTICE

| ACTION | RATIONALE | EVIDENCE (Please rank the evidence as recommended) |
|---|---|---|
| Staff preparing Clinical Guidelines will comply with PHPSWI07 001U Preparation and approval of clinical guidelines | Following the Work Instruction ensure a consistent format for Clinical Guidelines. | See attached PHPSWI07 001U |
| Clinical Guidelines will be submitted for approval to Committees specified in PHPSWI07 001U | This will ensure that all Clinical Guidelines are submitted to multidisciplinary committees for approval prior to publication | See attached PHPSWI07 001U |
| Clinical Guidelines will be published on the Portsmouth Hospitals Intranet Website and Portsmouth and SE Hants Extranet Website as read or print only documents, protected from amendment by password control. | This will ensure that all Clinical Guidelines are widely available to the Portsmouth and S E Hants health economy. The latest version will be maintained on the web-server, obviating the need for an alternative document control system | The Portsmouth Hospitals Pharmacy Service will maintain a web-server specifically for the purpose of making available controlled documents associated with the Clinical Support Division Quality Systems, Clinical Guidelines and Clinical Governance. |
| Clinical Guidelines will be subject to an audit programme such that compliance with recommendations is audited within one year after publication | This will ensure that recommendations are implemented and feedback obtained from interested parties, which may be useful to the review process | See attached PHPSWI07 001U |
| Clinical Guidelines will be subject to review at a frequency agreed by the Guideline Development Group but in addition new Clinical Guidelines will be reviewed within one year after publication | This will ensure that Clinical Guidelines are reviewed within one year of first publication and at intervals, thereafter, agreed with the group responsible for their development | See attached PHPSWI07 001U |

## 5. FORUM FOR DISCUSSION (FORUM OR WORKING PARTY)

Formulary and Medicines Group
Area Prescribing Committee

## 6. AUDIT STANDARDS / AUDIT TOOL

| ASPECT OF CARE/OUTCOMES | EXPECTED STANDARD/ TARGET | SOURCE OF DATA COLLECTION |
|---|---|---|
| Preparation of Clinical Guidelines will be in accordance with PHPSWI07 001U | 100% | Documentation of preparation process on PHPS Form 07 001U |
| Approval of Clinical Guidelines will be by Committees specified in PHPSWI07 001U | 100% | Documentation of preparation process on PHPS Form 07 001U |
| Publication of Clinical Guidelines will be Clinical Guidelines will be published as defined in this policy | 100% | Review of Portsmouth Hospitals Intranet Website and Portsmouth and SE Hants Extranet Website. |
| As a minimum, compliance with Clinical Guidelines will be audited within one year of first publication | 100% audits undertaken within one year | Documentation of audit process on PHPS Form 07 001U and appendices |
| As a minimum, content of Clinical Guidelines will be reviewed within one year of first publication | 100% reviews undertaken within one year | Documentation of review process on revised PHPS Form 07 001U |

## 7. EDUCATION & TRAINING

The availability of clinical guidelines should be highlighted in patient safety induction training for all staff involved in the medication process. It should also feature in specific training for junior medical staff, including schemes for locum staff.

## 8. RISK MANAGEMENT

## 9. ASSOCIATED DOCUMENTATION

Appendix 1 PHPSWI07 001U Preparation, Approval, Publishing, Audit and Review of Clinical Guidelines (see overleaf)

Appendix 2 PHPS Form 07 001U Documentation of Preparation, Approval, Publishing, Audit and Review of Clinical Guidelines

# Preparation, Approval, Publishing, Audit and Review of Clinical Guidelines

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Originator:     Code A                                        Date: 24th March 2003

Authorised:    Jeff Watling                                   Date: 24th March 2003
               Head of Purchasing/Pharmacy Services Manager

Date Printed:  8 April 2003          Date of Last Amendment: N/A

## 1. Purpose and scope

Portsmouth Hospitals NHS Trust has a policy to ensure the consistent preparation, approval, publishing, audit and review of Clinical Guidelines. This Work Instruction describes how this will be achieved and documented.

## 2. Responsibility

2.1    The Head of Purchasing/Pharmacy Services Manager will be responsible for ensuring that this Work Instruction supports the Trust Policy for the Preparation, Approval, Publishing and Review of Clinical Guidelines.

2.2    All staff within Portsmouth Hospitals Pharmacy Service will be responsible for ensuring that this work instruction is followed and that requirements for review and amendment are notified to the Departmental Manager.

## 3. References

3.1    ISO 9001:2000 para 4.2.3 Control of Documents

3.2    Trust Policy and Protocol for preparation, approval, publishing, audit and review of clinical guidelines

## 4. Definitions:

4.1    **PHPS** – Portsmouth Hospitals Pharmacy Service

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4.2 **Clinical Guidelines** - Guidance documents prepared to assist clinicians, nurses and pharmacists in the safe control and administration of medicines for specific clinical conditions.

4.3 **Guideline Project Manager** A member of pharmacy staff designated, by the Pharmacy Services Manager to project manage the process for development of a clinical guideline.

4.4 **Guideline Development Group** A group established by a Guideline Project Manager to prepare a Clinical Guideline.

5. **Format of Clinical Guidelines**

5.1 All Clinical Guidelines prepared by Portsmouth Hospitals Pharmacy Service will follow the format specified in this Work Instruction.

5.2 All text will be in Arial font type (or equivalent) and 12 point font size throughout unless otherwise indicated

5.3 Format of Text

5.3.1 The front page will carry the following information:

a) Standard header (see attached example) Including a guideline reference number, approval date by Formulary and Medicines Group and review date (see attached example)
b) Title in the form a bordered text box or single column single row table with white on black text font size 16pt (see attached example).
c) Introduction defining the reasons for the Clinical Guideline, its objectives and the patients to whom it will apply.
d) Main text in the format of attached example
e) Reference to appendices, associated forms etc.

6. **Process for preparation of Clinical Guidelines**

6.1 The Pharmacy Services Manager will ensure that a system is in place to ensure that a member of pharmacy staff will be designated to project manage the process for development of clinical guidelines.

6.2 Clinical Guidelines will be prepared independently, by NHS employees working within the Portsmouth and South East Hampshire Health Economy. Preparation of Clinical Guidelines will be independent of funding or editorial influence from the pharmaceutical industry.

6.3 The Guideline Project Manager will establish a Guideline Development Group with representation from professional interests e.g. clinicians from appropriate specialities, nurses, pharmacists and other healthcare professionals

6.4 The Guideline Project Manager will ensure that, where appropriate, there is representation form other interest groups – including patients, during the guideline preparation process.

6.5 The Guideline Project Manager will document membership on PHPS Form 07 001U.

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6.6   The Guideline Project Manager will document the sources of information used to select the evidence, on which the guidelines are based.  Key references will be listed in the Clinical Guideline but all references used will be documented on PHPS Form 07 001U.

6.7   The Guideline Project Manager will document, where possible, the methods used to interpret and assess the strength of evidence, on which key recommendations are made.  In particular there should be an explicit link between major recommendations and the level of supporting evidence.

6.8   The Guideline Project Manager will document the methods used to formulate the recommendations.  In particular a record will be made of how the views of interested parties not on the Guideline Development Group were taken into account.

6.9   If the Clinical Guideline is to be piloted prior to implementation the Guideline Project Manager will manage the pilot study, document changes to the Clinical Guideline as a result of the pilot study on PHPS Form 07 001U.  Documentation of audits associated with the pilot study will be appended to PHPS Form 07 001U.

6.10  The text of the Clinical Guideline should include as a minimum:

- the reasons for developing the Clinical Guideline
- the objectives of the Clinical Guideline
- a description of the patients to which the Clinical Guideline should apply
- definitions
- a description of the condition to be detected, treated or prevented
- a definition of alternative options for management of the condition, e.g. first/second line treatment, medical or surgical management
- a presentation of the recommendations
- a statement of how the Clinical Guideline is to be disseminated
- a description of the health benefits likely to be gained from following the recommendations
- a description of the potential harm or risks that may result from the recommended management
- reference(s) to key national guidelines

6.11  In addition, the text of the Clinical Guideline may include:

- estimated costs of expenditures likely to occur from the recommended management
- an explicit statement of how patient preferences should be taken into account in applying the guidelines
- If appropriate, the identification of standards or targets or measurable outcomes, that can be monitored

7   **Approval**

7.1   The Guideline Project Manager will ensure that Clinical Guidelines are independently approved before publication.  As a minimum this will be through the following:

- Formulary and Medicines Group
- Sub Group of Clinical Governance Committee.

    In addition, any guidelines likely to affect elderly patients or other patients within the care of Primary Care Trusts will be through the following:

- Guidelines and Medicines Management Committee
- Area Prescribing Committee

7.2     The Guideline Project Manager will document approval dates on PHPS Form 07 001U

## 8     Publishing

8.1     On completion of the approval process the Guideline Project Manager make any necessary amendments and prepare a final version ready for publishing.  This will then be passed to the appropriate document controller for publishing on the Trust Intranet Web-site.

8.2     The Guideline Project Manager will document final version and publishing dates on PHPS Form 07 001U

## 9     Audit and Review

9.1     The Guideline Project Manager will liaise with the Guideline Development Group to agree a review date for the Clinical Guideline and organise a method for review approximately three months prior to the review date.  This process will be documented on PHPS Form 07 001U. The review process will be documented using a new PHPS Form 07 001U.

9.2     The Guideline Project Manager will liaise with the Guideline Development Group to agree an audit process for the Clinical Guideline and organise an audit, preferably in conjunction with the Clinical Audit Manager for the Trust(s) concerned.  Documentation of audits associated with the pilot study will be appended to PHPS From YY.  Any reviews of the Clinical Guideline as a result of the audit process will be documented using a new PHPS Form 07 001U.

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# Record of Preparation, Publishing, Audit and Review of Clinical Guidelines

**Preparation**

| Title of Clinical Guideline | | |
|---|---|---|
| | | |
| **Name of Guideline Project Manager** | | |
| **Membership of Guideline Development Group** | **Name** | **Date** |
| | | |
| **References used in preparing Clinical Guideline** | | |
| | | |
| **Methods used to interpret strength of evidence** | | |
| | | |

Portsmouth Hospitals NHS Trust
Pharmacy Service

**Methods used to formulate recommendations**

**Documentation of Review Process**

| Group | Date |
|---|---|
| Initial proposal to Guideline Development Group | |
| | |
| | |
| | |
| | |
| Finalisation by Guideline Development Group | |

**Documentation of Pilot Process**

| Pilot Process | Duration |
|---|---|
| | |
| Audit of Pilot Process | |
| | |

| Documentation of Minimum Requirements not included | | |
|---|---|---|
| **Requirement** | **Inc** | **Reason for exclusion** |
| Reasons for developing clinical guideline | | |
| Objectives of clinical guideline | | |
| A description of patients to whom the guideline should apply | | |
| A clear description of condition to be detected, treated or prevented | | |
| Clear description of health benefits likely to be gained from following the guidelines | | |
| Clear definition of alternative options for management of the condition | | |
| Statement of how the guideline to be disseminated | | |
| Clear presentation of the recommendations | | |
| An adequate description of harms and risks associated with recommended management | | |
| Reference to key national guidelines | | |

| Documentation of Additional Requirements not included | | |
|---|---|---|
| **Requirement** | **Inc** | **Reason for exclusion** |
| Estimated costs of expenditures likely to occur from the recommended management | | |
| Explicit statement of how patient preferences should be taken into account in applying the guidelines | | |
| Clear definition of standards or targets or measurable outcomes, that can be monitored | | |

**Approval**

| Documentation of Approval Process | |
|---|---|
| **Group** | **Date** |
| Approval by Formulary and Medicines Group | |
| Approval by Guidelines and Medicines Management Committee | |
| Approval by sub-committee of Clinical Governance Committee | |
| | |

**Publishing**

| Final version prepared by Guideline Project Manager | Date |
|---|---|
| Name<br>Guideline Project Manager | |
| **Final version place on intranet website** | **Date** |
| Name<br>Document Controller | |

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**Review and Audit**

| Review date agreed with Guideline Development Group | Date |
|---|---|
| Proposed review date | |
| **Proposed review methodology** | |
| | |
| **Review completed** | **Date** |
| Name<br>Guideline Project Manager | |
| **Revised version prepared by Guideline Project Manager** | **Date** |
| Name<br>Guideline Project Manager | |
| **Revised version place on intranet website** | **Date** |
| Name<br>Document Controller | |

Detailed documentation of review of each clinical guideline will be undertaken using a new PHPS Form 07 001U in accordance with the requirement of PHPSWIYY

| Audit date agreed with Guideline Development Group | Date |
|---|---|
| Proposed audit date | |
| **Proposed audit methodology** | |
| | |
| **Audit completed** | **Date** |
| Name<br>Guideline Project Manager | |
| **Revised version prepared by Guideline Project Manager** | **Date** |
| Name<br>Guideline Project Manager | |
| **Revised version place on intranet website** | **Date** |
| Name<br>Document Controller | |

Detailed documentation of audits of each clinical guideline will be undertaken using a new PHPS Form 07 001U in accordance with the requirement of PHPSWI07 001U