**EXPANDED PRACTICE PROTOCOL CHECKLIST – Form 1 **

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| --- | --- | --- | --- |
| Title of Protocol:  |  | Practice Protocol No:  |  |
| Group Member:  |  | Date:  |  |

| Section  |  | Yes | **No** | N/A | Reasoning |
| --- | --- | --- | --- | --- | --- |
|  | Does the title represent the practice? |  |  |  |  |
|  | Is the expanded practice description clear? |  |  |  |  |
|  | Are the members of the development team appropriate? |  |  |  |  |
|  | Is the professional group appropriate? |  |  |  |  |
|  | Is the patient group described clearly? Is the age range clear? |  |  |  |  |
|  | Is the clinical setting suitable? |  |  |  |  |
|  | If new, does this procedure need to be ratified at a Trust level? |  |  |  |  |
|  | Is the expanded practice appropriate? |  |  |  |  |
|  | Are the benefits to the patient clear and achievable? |  |  |  |  |
|  | Are the consequences of not changing significant? |  |  |  |  |
|  | Is the aim relevant? Are the objectives SMART? |  |  |  |  |
|  | Is the implementation date realistic? |  |  |  |  |
|  | Is the proposed administration of medication appropriate? |  |  |  |  |
|  | Is the medicine listed? |  |  |  |  |
|  | Has the practitioner identified an appropriate method of prescription? |  |  |  |  |

|  |  |
| --- | --- |
|  | RECOMMENDATION |
|  **Approved** |  **Accepted with Revisions** |  **Refused** |