**Intention to Develop an Expanded Practice **

**Directorate Authorisation Form**

1. **Expanded Practice Title**
2. **Is this included in the Directorate Service Plan?**

|  |  |
| --- | --- |
| **Yes** | **🞎** |
| **No** | **🞎** |

1. **Is this included in the practitioners Professional Development Plan?**

|  |  |
| --- | --- |
| **Yes** | **🞎** |
| **No** | **🞎** |

**Confirmation of approval to proceed with the “Intention to Develop an Expanded Practice” (form 1) application:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name****(please print)** | **Signature** | **Date** |
| **Directorate Senior Nurse or** **Directorate Manager** |  |  |  |
| **Clinical Assessor**  |  |  |  |

**Developing Expanded Practice EPP Form 1**

1. **Expanded Practice Title (Brief)**
2. **Expanded Practice description**

*Please briefly describe what the procedure involves. Consider attaching product information or references to national guidance as this will help the validation team understand the nature of the proposed practice change.*

1. **Names and titles of the protocol development team**

(For expanded practice involving medicines, a doctor must be included)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** |  | **Job Title** |
| **Practitioner:** |  |  |  |
| **Directorate Senior Nurse:** |  |  |  |
| **Clinical Assessor:** |  |  |  |

1. **Professional Group**

*E.g. nurse, physiotherapist, midwife etc*

1. **Patient group/area of practice**

*E.g. adults, children etc.*

1. **State the clinical setting**

*E.g. ward, outpatient clinic, theatre etc*

1. **Is this a new procedure?**

|  |  |
| --- | --- |
| **Yes** | **🞎** |
| **No** | **🞎** |

1. **Who currently undertakes the proposed expanded practice?**

*E.g. doctor, technician, nurse practitioner, physiotherapist etc*

1. **Why does this need to change and what are the patient benefits?**

*Is there evidence of a national driver for change e.g. national service framework or CQUIN?*

1. **What are the possible consequences to patient care of not changing?**

*Increased length of stay, increased morbidity, treatment delay etc*

1. **Aim**

*Consider your response to section 9 and state the expected outcome of this change e.g. decreased waiting times, length of stay etc*

1. **What is the proposed date for the expanded practice implementation?**

*Take into account the time needed to complete educational training or need to submit the practice to other Trust committee’s i.e. Increasing Access to Medicines Group*

1. **Does this involve the administration of medicine?**

|  |  |
| --- | --- |
| **Yes** | **🞎** |
| **No** | **🞎** |

1. **List the medicines involved**
2. **Are you an independent prescriber or will the medicines be supplied/administered through a Patient Group Directive (PGD) or Locally Agreed Clinical Procedure (LACP)?**

|  |  |
| --- | --- |
| **Submitted by:** |  |
| **Directorate** |  |
| **Contact number:** |  |
| **Email address:** |  |
| **Date:**  |  |

**Please submit the completed form electronically to:**

**The chair of the *Expanded Practice Validation Group***