Appraisal Support Pack
Prescribing Decisions

Appraisal support packs

This pack is one in a series of educational resources, which have been designed to help doctors prepare for their appraisal. It has been developed by HEIW.

The pack is designed to give doctors ideas about how they might review their practice and learning in specific practical areas, including for example prescribing. The pack provides guidelines on the types of issues doctors might wish to consider in relation to these areas, and about how they might collect, record and structure this information. The pack includes templates, which will help doctors structure this information in a format, which can meaningfully be included in the appraisal process.

It is hoped that the pack will help doctors to collect information based on their day-to-day practice without necessitating a large amount of additional work. Some of this information may already be available to doctors, including for example through clinical governance activities managed by the Local Health Board. It should be noted that while the information may be the same, the purposes of the activities are separate and distinct. These packs are designed to help doctors reflect on the implications of this information for their personal learning and development and do not form part of any clinical governance or performance management process.

Using the materials for appraisal

It is not compulsory that doctors use these packs; they are available as an additional resource for those who wish to make use of them. It is not suggested that an individual completes all the sections every year; rather it may be used as a guide to produce information for appraisal in a structured format. This should enable the appraisal discussion to become more focussed.

The templates encourage and promote written reflection on the subject areas, and if followed will produce an entry that may be copied and pasted into the appraisal web site boxes under 'My Appraisal Information' and then use the 'New Personal Evidence' template. Or, simply uploaded to the web site with just the title field completed to aid the appraiser in understanding the content of the file. Doctors should use these materials in the way they feel is most appropriate to them and meaningful to their appraisal, and avoid duplication of work or information.

Prescribing Decisions

Prescribing decisions are made in the majority of consultations. The use of safe, cost effective and appropriate drugs is the mainstay in the treatment of many chronic disease conditions. By using some of the exercises contained within this pack you should be able to demonstrate your prescribing behaviour and perhaps move forward in some areas.

Contents

1: Knowledge, Skills and Performance

Reflecting on your learning

Using PUNs and DENs to record patient experiences

2: Safety and Quality

Annual LHB prescribing visit and report

Prescribing Audit Report (PAR) Analysis

Self-assessment questionnaire (prescribing)

Evidence based prescribing

Case report (prescribing)

Reflecting on prescribing

Audit in prescribing

Significant event analysis

3: Communication, Partnership and Teamwork

Repeat prescribing

Section 3a: Working with patients
Section 3b: Working with colleagues

4: Maintaining Trust

Use of new drugs – relationship with industry

5: Resources for sessional GPs

Prescribing Habits Questionnaire

Section 1: Knowledge, Skills and Performance

Section 1a: Reflecting on your learning

In this section you may include learning experiences. There are many resources developed and available to help you. The WeMeReC site has some useful learning modules http://www.wemerec.org/index.htm as has the BMJlearning site http://www.bmjlearning.com/planrecord/index.jsp

Once completed it is important to reflect on what the learning experience means for your day-to-day practice and to highlight any changes you have made.

Learning affecting prescribing

Description of learning experience

As a result do I need to change my prescribing?

Do I need further study or updating?

Example

Learning affecting prescribing

Description of learning experience
I attended an update on respiratory medicine; this included a section on COPD. The speaker introduced tiotropium as a possible addition to treatment. Evidence was presented showing it to be more effective than older anticholinergic inhaled drugs (handout available to appraiser). It was suggested to give patients at least a one month trial and possibly two before assessing its effectiveness.

As a result do I need to change my prescribing?
I had used this drug previously and found patients complained of a lack of effectiveness – this is possibly due to me assessing them after a few weeks only and by relying mainly on reported effects not objective measures of lung function. I will in future prescribe this for at least six weeks and consider using spirometry as an objective measure of response.

Do I need further study or updating?
The section on interpretation of spirometry in this meeting was run as a parallel session to another on asthma that I attended and as such I missed this – I would like to learn more about this over the next year and will include it in my PDP

Example

Learning affecting prescribing

Description of learning experience

A patient attended with severe sleep disturbance due to leg jerking, I wondered if the diagnosis was restless leg syndrome. I have seen and made a diagnosis of restless legs in many patients but the degree of sleep disturbance experienced by this patient was much greater than my previous patient encounters. I was unable to make a firm diagnosis nor suggest treatment. I promised to look it up and contact the patient.

I performed a search on Tripdatabase (http://www.tripdatabase.com) which directed me to an excellent diagnostic and management aid for restless legs on the Clinical Knowledge Summaries (CKS) site http://cks.nice.org.uk/restless-legs-syndrome#!topicsummary the same database also directed me to recent trial data on the Cochrane database: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006009.pub2/abstract on Dopamine therapy and http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005504.pub2/abstract;jsessionid=D01C70 D45B9F19115EE13CE83590031B.f01t04 on Levodopa. From studying these articles and asking the patient the diagnostic questions I was able to ascertain that the likely diagnosis was restless leg syndrome and decided to try Pergolide (a drug I had very little previous experience of). The patient made an excellent recovery and although there was still some sleep disturbance from the legs the patient was very happy with the result.

As a result do I need to change my prescribing?

This single patient contact has led me to a greater understanding of restless leg syndrome and the effects it may have on patient well being. I have learned from the Cochrane articles that Pergolide and Levodopa are potentially the most effective drugs in this condition but also that placebo can have a strong effect. The main concern was 'Augmentation' characterised by an earlier onset of symptoms during the day, faster onset of symptoms when at rest, spreading of symptoms to the upper limbs and trunk, and shorter duration of the treatment effect.

Do I need further study or updating?

I think I now have an excellent tool to aid my diagnosis of restless legs, I have more insight into the patient's symptoms and how they can affect quality of life and I seem to have found the most effective treatments available. I will watch for developments in this area but do not feel that further learning is required at present

Section 1b: Using PUNs and DENs to record patient experiences

An alternative way of recording patient experiences is through PUNS and DENS (Patient's Unmet Needs and Doctors Educational Needs, the example above could look like this:-

Example of Learning affecting prescribing above – with PUNS and DENS

Identify PUN

A patient attended with severe sleep disturbance due to leg jerking, I wondered if the diagnosis was restless leg syndrome. I have seen and made a diagnosis of restless legs in many patients but the degree of sleep disturbance experienced by this patient was much greater than my previous patient encounters. I was unable to neither make a firm diagnosis nor suggest treatment

PUN

No diagnosis possible
No treatment option given

Describe the PUN

Patient's complaint taken seriously but only a tentative diagnosis of restless legs given Even with tentative diagnosis unable to give treatment

Record the DEN

I need to know more about the diagnosis and treatment of Restless leg syndrome

Fulfil the DEN

I performed a search on Tripdatabase (http://www.tripdatabase.com) which directed me to an excellent diagnostic and management aid for restless legs on the Clinical Knowledge Summaries (CKS) site http://cks.nice.org.uk/restless-legs-syndrome#!topicsummary the same database also directed me to recent trial data on the Cochrane database: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006009.pub2/abstract on Dopamine therapy and http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005504.pub2/abstract;jsessionid=D01C70 D45B9F19115EE13CE83590031B.f01t04 on Levodopa. From studying these articles and asking the patient the diagnostic questions I was able to ascertain that the likely diagnosis was restless leg syndrome and decided to try Pergolide (a drug I had very little previous experience of). The patient made an excellent recovery and although there was still some sleep disturbance from the legs the patient was very happy with the result.

Section 2: Safety and Quality

Section 2a: Annual LHB prescribing visit and report

Each year, practices are invited to sit down with their LHB prescribing advisors and read and reflect on the annual practice prescribing report, discuss agreed actions from the previous year and agree more actions for the year ahead. The report contains information on prescribing within certain areas of interest to the LHB's such as the use of antibiotics and non-steroidal anti-inflammatory drugs (NSAIDs), the rates of use of drugs not favoured for their efficacy etc and compares the results to the average for the LHB area and Wales as a whole. Practices and individuals are encouraged to reflect on these results and plan action as necessary. The actions arising from the report and the agreed objectives chosen from a list of tasks proposed by the LHB's will have implications for the appointed LHB prescribing advisors, the practice as a whole, the prescribing lead GP (if one exists) and individual GPs where appropriate. Further prescribing information may be available from quarterly local prescribing meetings where representatives from practices are invited to attend and disseminate information back to their practices.

The Annual Practice Prescribing Report, annual prescribing meeting and quarterly update meetings may be used to examine the overall prescribing trends of your practice. A suggested template for this analysis is included below. Reflection on the report can be entered as an appraisal entry and the document uploaded as supporting documentation.

Annual Prescribing and Medicines Management Report

Annual Prescribing and Medicines Management Report	
What were the agreed actions from last year's meeting?	
What progress has been made?	
Any Further action required?	
Prescribing Management Scheme	
What areas of the Prescribing Management Scheme were agreed for the practice last year?	

What were the targets for these areas and how did the practice do?

Area	Target for full payment	Target for partial payment	Points achieved

Any Further action required?	

National Prescribing Indicators

How did the practice perform in the National Prescribing Indicators?

Any Further action required?	

Agreed Actions For The Next Twelve Months

Will you have any personal involvement?

Example

Annual Prescribing and Medicines Management Report
What were the agreed actions from last year's meeting?
1. To review patients on hypnotics and introduce withdrawal schedules *2. To review patients on Buprenorphine patches against guidelines and switch where appropriate* *3. To review patients prescribed ferrous sulphate and gluconate and switch to ferrous fumarate*

What progress has been made?	*1. Ongoing, reduction in some patients demonstrated* *2. Completed, reduction demonstrated* *3. Completed, increase in ferrous fumarate and reduction in sulphate and gluconate*
Any Further action required?	*Not all patients on hypnotics have been started on withdrawal regimes, this is ongoing and in hand. The prescribing advisors are working their way through the list. No further GP input needed.*

Prescribing Management Scheme
What areas of the Prescribing Management Scheme were agreed for the practice last year?
1. Top 9 antibacterials as a % of antibacterials *2. Low acquisition cost (LAC) statins as a % of total statins and Ezetemibe* *3. NSAIDs DDDs per 1000 Pus*
What were the targets for these areas and how did the practice do?

Area	Target for full payment	Target for partial payment	Points achieved
Top 9 antibacterials	*> 84.65%*	*80-84.64%*	*84.21*
Low acquisition cost (LAC) statins	*>95.29%*	*90-95.28%*	*91.97*
NSAIDs	*<1739.89*	*1739.9 - 3000*	*3202.94*

Any Further action required?	*We were just outside the maximum points for antibacterial, just made the lowest payment for LAC statins and way off for NSAIDs. The latter has been an ongoing issue for us and we seem to have a culture of prescribing these rather than suggesting patients buy their own. We will continue the progress made on the other two areas and expect the position to change on statins given that atorvastatin is now off patent and have all agreed to push over the counter (OTC) NSAIDs rather than prescribe.*

National Prescribing Indicators

How did the practice perform in the National Prescribing Indicators?

We were positioned roughly mid way for most of the national indicators, which included the three agreed above. We were less than average for the following:

These results further shed light on our NSAID issue where we were not just higher prescribers of NSAIDs but also had a low rate of ibuprofen and naproxen prescriptions as a % of total NSAIDs. This means we are prescribing too much of drugs like diclofenac still which I'm aware carries a higher embolic risk than other NSAIDs. We also had a high PPI prescribing rate compared to most other practices and this may reflect our higher NSAID rate if being used appropriately for GI protection. Even so, reducing NSAIDs will then reduce PPI usage.

The statin that stopped us achieving the higher rate for LAC statins was Olmesartan! – This will need looking into.

Finally, our triptans were higher than average and we all agreed to review our migraine management in line with current guidance.

Any Further action required?	*1. Agree a policy on NSAIDs* *2. Review Olmesartan prescriptions* *3. Agree a guideline on migraine management*

Agreed Actions For The Next Twelve Months

1. *Repeat prescribing audit*
2. *Review patients on NSAID repeats and change to naproxen or ibuprofen s appropriate*
3. *Review patients on Minocycline as repeat and switch to suitable alternative*

Will you have any personal involvement?

I volunteered to review patients on Minocycline and check their management against guidelines for acne and rosacea as appropriate. If patients will not come off it, I will check if they have had relevant blood tests where necessary and have had the potential side effects explained and recorded. I will then attempt to switch others where appropriate. In addition I will prepare a practice protocol for acne management, as this seems to be very variable within the practice. I will source this from the local dermatology guidance on the LHB portal and triangulate with evidencebased sources such as NICE, SIGN and TRIP database. We will then meet to agree it (or amend it) at a practice meeting. I plan to do this in the next 6 months and it will then be ready to discuss at my next appraisal as another piece of quality improvement evidence.

Section 2b: Prescribing Audit Report (PAR)

Practices can find their own quarterly and annual prescribing information for comparison. Below is a suggested template to help the analysis of the report for the practice and aid personal development for appraisal. Reflection on the report can be entered as an appraisal entry and the document uploaded as supporting documentation.

Prescribing Audit Report (PAR) Analysis Template

Prescribing Audit Report (PAR) Analysis Template			
Period Reviewed		To	
What is your projected under- or overspend?			
What is the practice generic prescribing rate?	Locality equivalent	LHB equivalent	National equivalent
Look at the total cost and number of items prescribed. Compare this with the Local, LHB and national average			
Your Practice	£	Nu	Cost ratio
Locality	£	Nu	
LHB equivalent	£	Nu	
National	£	Nu	
Are there large differences?			
Within each therapeutic group (Gastro intestinal, cardiovascular etc) look at the total number of practice items prescribed and total cost per therapeutic group and compared to the locality average.			

Therapeutic group (e.g. gastro intestinal, cardiovascular)	Number of items prescribed	Locality equivalent	Ratio	Cost per therapeutic group	Locality equivalent	Ratio
1.				£	£	
2.				£	£	
3.				£	£	
4.				£	£	
5.				£	£	
6.				£	£	
7.				£	£	

Do any of the above differ wildly from the locality?	

What are your practice's top 5 sections from the Practice Top 25 Sections by cost? (E.g. Drugs used in diabetes, corticosteroids, analgesics etc)

Top 5 sections	Practice Top 25 Sections by cost (E.g. Drugs used in diabetes, corticosteroids, analgesics etc)	Cost	Ratio to locality
1.		£	
2.		£	
3.		£	
4.		£	
5.		£	

Do any of the above differ wildly from the locality?	

What are your practice's top 5 types of drugs prescribed from the Top 25 chemicals by number? (e.g. analgesics, lipid lowering drugs, antidepressants etc)

Top 5 sections	Practice Top 25 Sections by items prescribed (e.g. analgesics, lipid lowering drugs, antidepressants etc)	Number	Ratio to locality
1.			
2.			
3.			
4.			
5.			

Do any of the above differ wildly from the locality?	

What are the 5 most common drugs (from Practice Top 25 Chemicals) prescribed by the practice? (E.g. Simvastatin, aspirin, bendroflumethiazide etc)

Top 5 drugs	Practice Top 25 chemicals by numbers prescribed (E.g. Simvastatin, aspirin, bendroflumethiazide etc)	Numbers	Ratio to locality
1.			
2.			
3.			

4.			
5.			

Do any of the above differ wildly from the locality?	

What are the 5 most expensive drugs prescribed by the practice?

Top 5 drugs	Practice Top 25 chemicals by cost (E.g. Fluticasone, Budesonide, 'others' etc)	Cost	Ratio to locality
1.		£	
2.		£	
3.		£	
4.		£	
5.		£	

Do any of the above differ wildly from the locality?	

List 3 to 5 areas for discussion with the LHB practice prescribing advisors. This may include suggestions for audit, examination of evidence, writing of protocols or switches.

Date discussed with practice team:	

Action plan, including timescales and by whom

Agreed Action	Time scale / date for completion	Who's involved
Pending Practice meeting with prescribing advisors		

Example

Prescribing Audit Report (PAR) Analysis Template			
Period Reviewed	*April 2013*	To	*June 2013*
What is your projected under- or overspend?		*8.4% oversepend*	
What is the practice generic prescribing rate?	Locality equivalent	LHB equivalent	National equivalent
86%	*85%*	*85%*	*84%*

Look at the total cost and number of items prescribed. Compare this with the Local, LHB and national average			
Your Practice	*£420,077*	Nu *54,991*	Cost ratio
Locality	*£ 381,331*	Nu *54,089*	*1.1*
LHB equivalent	*£427,414*	Nu *57,179*	*0.98*
National	*£424,484*	Nu *54,954*	*0.99*
Are there large differences?	*No – so why the 8.4% predicted overspend? – Will discuss with prescribing advisors*		

Within each therapeutic group (Gastro intestinal, cardiovascular etc) look at the total number of practice items prescribed and total cost per therapeutic group and compared to the locality average.

Therapeutic group (e.g. gastro intestinal, cardiovascular)	Number of items prescribed	Locality equivalent	Ratio	Cost per therapeutic group	Locality equivalent	Ratio
1. GI	*4726*	*4797*	*0.99*	*£23868*	*£19867*	*1.2*
2. CV	*16482*	*16128*	*1.02*	*£52944*	*£55107*	*0.96*
3. Resp	*4395*	*4070*	*1.08*	*£67004*	*£58180*	*1.15*
4. CNS	*10514*	*10594*	*0.99*	*£81970*	*£69330*	*1.18*
5. Infections	*2511*	*2368*	*1.06*	*£10721*	*£10380*	*1.03*
6. MSK	*2039*	*1821*	*1.12*	*£10992*	*£9205*	*1.19*
7. Other	*14324*	*14312*	*1.0*	*£172576*	*£159259*	*1.08*

Do any of the above differ wildly from the locality?	*Gastro, respiratory, CNS and MSK are the largest differences – we will need to 'drill down' into these areas to see what the offending drugs are.*

What are your practice's top 5 sections from the Practice Top 25 Sections by cost? (E.g. Drugs used in diabetes, corticosteroids, analgesics etc)

Top 5 sections	Practice Top 25 Sections by cost (E.g. Drugs used in diabetes, corticosteroids, analgesics etc)	Cost	Ratio to locality
1.	*Diabetes drugs*	*£42424*	*1.3*
2.	*Corticosteroids (respiratory)*	*£42004*	*1.15*
3.	*Analgesics*	*£33048*	*1.25*
4.	*Lipid reducing drugs*	*£23800*	*1.1*
5.	*Oral Nutrition*	*£15682*	*1.15*

Do any of the above differ wildly from the locality?	*Lipid lowering drugs show the least difference, diabetes and analgesics the most. I run the diabetes enhanced service and I have a masters level qualification in it and attend regular updates. I do not feel my prescribing is out of step but this does reflect a high prevalence of diabetics in our practice population so no opportunity to modify this result. Analgesic use and NSAIDs in particular is a known issue we are targeting. The better lipids result reflects our work as part of the Prescribing Management Scheme.*

What are your practice's top 5 types of drugs prescribed from the Top 25 chemicals by number? (e.g. analgesics, lipid lowering drugs, antidepressants etc)

Top 5 sections	Practice Top 25 Sections by items prescribed (e.g. analgesics, lipid lowering drugs, antidepressants etc)	Number	Ratio to locality
1.	*Analgesics*	*4214*	*1.03*
2.	*Lipid lowering drugs*	*3403*	*1.01*
3.	*Antidepressant drugs*	*3312*	*1.07*
4.	*Antihypertensive therapy*	*3185*	*0.92*
5.	*Ulcer-healing drugs*	*2898*	*0.97*

Do any of the above differ wildly from the locality?	*None of these are far from the average although analgesics were our 3rd most expensive group of drugs – this likely means we are simply using the wrong (more expensive) ones. The better figures for antihypertensives is misleading as this likely relates to a lower pick up rate for hypertensives rather than efficient prescribing. This is evident from our QOF data.*

What are the 5 most common drugs (from Practice Top 25 Chemicals) prescribed by the practice? (E.g. Simvastatin, aspirin, bendroflumethiazide etc)

Top 5 drugs	Practice Top 25 chemicals by numbers prescribed (E.g. Simvastatin, aspirin, bendroflumethiazide etc)	Numbers	Ratio to locality
1.	*Simvastatin*	*2256*	*1.02*
2.	*Aspirin*	*1950*	*1.06*
3.	*Bendroflumethiazide*	*1574*	*1.46*

4.	*Omeprazole*	*1469*	*0.97*
5.	*Levothyroxine sodium*	*1421*	*1.0*

Do any of the above differ wildly from the locality?	*Bendroflumethiazide sticks out! I am aware that the UK is one of the last countries to use this routinely and that it is largely regarded as ineffective and can hasten the development of type 2 diabetes. Indapamide could be more effective and I will discuss this with the prescribing advisors and partners.*

What are the 5 most expensive drugs prescribed by the practice?

Top 5 drugs	Practice Top 25 chemicals by cost (E.g. Fluticasone, Budesonide, 'others' etc)	Cost	Ratio to locality
1.	*Fluticasone Proprionate*	*£25765*	*1.11*
2.	*Atorvastatin*	*£13572*	*1.08*
3.	*Budesonide*	*£11891*	*1.31*
4.	*'Others'*	*£11053*	*1.15*
5.	*Tiotropium*	*£9423*	*1.23*

Do any of the above differ wildly from the locality?	*Respiratory drugs have a dominant position in our top 5. We have an excellent nurse led respiratory clinic and have had mechanisms in place for a number of years to identify COPD patients earlier. I take these figures as a mark of success and as I oversee the nurse led clinic and keep the protocols up to date, I am confident the cost reflects best practice and simply a high prevalence. The atorvastatin costs will drop markedly when it goes off patent soon.*

List 3 to 5 areas for discussion with the LHB practice prescribing advisors. This may include suggestions for audit, examination of evidence, writing of protocols or switches.

1. *Why are we heading for an 8.4% overspend when our total prescribing numbers and costs do not vary wildly from the average? (though 2 below may shed some light!)*
2. *We need to drill down into the drug areas of Gastro, respiratory, CNS and MSK as these show the widest variance in cost and numbers from the average*
3. *Help with analgesic use and NSAIDs in particular*
4. *Bendroflumethiazide – what is the LHB position on this drug and should there be a switch to Indapamide or not favour thiazides at all?*

Date discussed with practice team:	*Practice meeting booked 24th March*

Action plan, including timescales and by whom

Agreed Action	Time scale / date for completion	Who's involved
Pending Practice meeting with prescribing advisors		

Section 2c: Self-assessment questionnaire

Repeat Prescribing consumes a considerable amount of doctor and administrative time in General Practice. It is open to error and therefore potential or actual patient harm. Use this questionnaire to record the repeat prescribing system in your practice. You may consider discussing it with the prescribers and prescribing clerks in your practice and document any changes you make as a result

Question	Your answer
Describe your practices arrangements for repeat prescribing; particularly highlight systems you have in place to ensure safety.	
How can patients request repeat prescriptions?	
How long after request can they collect prescriptions?	
Do you have any arrangements with other agencies to collect prescriptions on the patients behalf? – Please describe	
Who can authorise a medication to be added to a patients repeat list?	
Are there any medications you exclude from repeat lists?	
If a patient requests a medication that is not on the repeat list but has been issued before what happens?	
How do you review a patient's repeat medication?	
Has the person(s) who generates the prescription had training? – Please detail	
Do you dispense for your patients?	

If you dispense please set out in detail your arrangements to ensure safety and ongoing training arrangements for your dispenser.	
Use this box to outline changes made to your repeat prescribing systems in the last year	
How do you think your repeat prescribing system is functioning? Have you identified any areas for improvement?	

Section 2d: Evidence based prescribing

The management of most chronic diseases involves prescribing issues. Many practices have stepwise protocols to ensure treatment of chronic diseases is optimised. Practice protocols should use current best evidence or national guidelines (e.g. NICE, BTS guidelines). You may wish to use this section to demonstrate the management of a patient over a period of time using such a protocol/guideline. (See below for an example).

Please provide the patient history:
Please indicate the guideline / protocol used and where the management of this patient follows the document and any variation away from it if appropriate:

Example

Patient history:
64 year old male *2006 – presented with thirst and polyuria type 11 diabetes diagnosed initial fasting glucose 9.2. Advised re diet exercise and weight loss. Initially does well with glycaemia controlled on no medication.* *2009 – regular monitoring reveals worsening control with a HBa1c of 8.9%. Metformin started as BMI 32, hypertensive with no end organ damage, Ramipril started U+E checked normal.* *2010 – Metformin dose increased in attempt to improve control – simvastatin commenced as cholesterol 6.1 mm/l and has hypertension and cardiovascular risk now > 20% using JBS tool. Later in the year gliclazide commenced initial glycaemic control excellent.* *2013 Now taking maximum doses of metformin and gliclazide control sub optimal – possible referral for consideration of GLP-1 Analogue or insulin therapy, but feel a trial of a Gliptin worth a go and agreed with patient. Blood pressure increased and microalbuminuria just started, optimise Ramipril and start Aspirin as a primary prevention. Simvastatin optimised – total cholesterol now 3.9 mm/l* *2014 Well established on triple therapy. Improvement in glycaemic control – no change in management plan but if HbA1c worsens, will need to consider referral as not yet initiating GLP-1 analogues or insulin in practice and growing evidence against starting a glitazone though would discuss this further with patient. Also, though no direct experience as yet, could consider newer* dapagliflozin *drug provided eGFR remains good*
Please indicate the guideline / protocol used and where the management of this patient follows the document and any variation away from it if appropriate
I believe that the management of this patient is sound and evidence based. The use of a gliptin is in accordance with NICE guidelines and the protective medications are appropriate • *ACE inhibitor for hypertension appropriate first line treatment in a relatively young patient* • *Aspirin indicated due to the raised cardiovascular risk (hypertension, microalbuminuria plus diabetes)* • *Statin therapy for those aged > 40 years when cardiovascular risk reached 20% or more.* *The patient probably warranted aspirin and simvastatin earlier but it seems now that this treatment is optimal.*

Section 2e: Case report

Sometimes an individual case can be used to demonstrate your prescribing behaviour. You may choose to highlight a case that has illustrated a learning point for yourself.

Example

Describe the case and prescribing issues:
What action did you take and why?
Learning points identified:

Describe the case and prescribing issues:
Patient is a 69 year old man with longstanding diabetes (Type 2 requiring insulin). PH of MI in 1990. Lives with wife able to play 9 holes of golf usually lifetime non smoker BMI 36. Medication prior to February 2014 – Aspirin 75mg od, Ramipril 10mg od, Furosemide *40mg od, Isosorbide Mononitrate 20mg bd, Orlistat tds,* Atorvastatin *20mg od, Insulin glargine 90 units nocte, Novorapid penfil 29 units mane and lunchtime, Metformin 850mg bd, Doxazosin 4mg od. An example of polypharmacy but has well controlled blood pressure and is reasonably well. Recent echocardiogram normal.* *February 2014 – presents with shortness of breath and ankle swelling. Found to be in AF rate 120 and signs and symptoms of LVF. I made a diagnosis of failure secondary to fast AF and initiated a betabloker for rate control and increased his diuretics, at this point I also requested a further cardiological opinion re the possibility of cardioversion.*
What action did you take and why?

February – June 2014 Patient reviewed regularly – AF with rate of 80-100 still SOB discussion re warfarin considering the patients age, previous MI and Diabetes – patient initially unsure, given prodigy leaflet on warfarin in AF – he decides to go ahead. Warfarinisation carried out as per practice protocol uneventful. He did not appear to be tolerating the betablocker so on discussion with the cardiology consultant and pending his appointment in cardiology I have started Sotolol.

June 20014 – goes privately to cardiologist who arranges an echo, this shows gross lvf with a large diskinetic anterior segment consistent with a new MI, spironolactone and bumetanide started and the sotolol was changed to amiodarone, improvement in shortness of breath.

Learning points identified:

This case illustrates a number of points:- ☐ I correctly identified the AF

- *The treatment choices for the AF were appropriate*
- *Appropriate use of anticoagulation – practice protocol available*
- *I failed to identify the MI – the initial ecg taken at the practice does not show changes (apart from AF) and the cardiologist commented before the echo "the ecg shows AF" after the echo he reviewed the ecg and still does not identify ischaemia*
- *This patient is currently taking "best evidence" medication*

I will over the next year review the interpretation of ECGs

Section 2f: Reflecting on prescribing

Try to think of a drug that you have prescribed for the first time or prescribe infrequently

Name of drug:
Mode of action:
Why did I choose this drug?
What was I trying to achieve for this patient?

Is this the most effective drug in this situation?
Learning points or changes made

Try to think of a drug that you have prescribed for the first time or prescribe infrequently

Name of drug
Dapagliflozin
Mode of action
A new oral treatment for type 1 or 2 diabetes – works on the renal tract to inhibit SGLT2. SGLT2 resorbs glucose from the renal tubules. Inhibiting it deliberately causes more glycosuria – keeping blood glucose down, losing calories. It does take some water with it but voiding only increased by another 1.5 times a day, there are more UTIs and thrush however. The extra water loss can help lower BP.
Why did I choose this drug?
I have a few patients who have maximised oral therapy on metformin, gliclazide and a gliptin. Their HbA1c has remained elevated however and they really do not want to be referred for hospital care and potentially injectable medications.
What was I trying to achieve for this patient?
The particular patient in question is a 65 year old man whose diabetes has become increasingly harder to control on a combination of metformin and gliclazide and a gliptin and as he has had diabetes for greater than 10 years, it is likely he has a degree of myocardial ischaemia and so pioglitazone is too risky an option. He would find travelling to hospital very difficult as an amputee with mobility problems and no carers. His options are probably limited to a GLP-1 agonist or insulin therapy. I am hoping to see improved glycaemic control with a reduction in his HBa1c from the current 8.8% to closer to 8 or below.
Is this the most effective drug in this situation?
Given that only a glitazone is the only other primary care option and he does not want to be referred and there is a possibility of achieving close to optimal HbA1c – yes.
Learning points or changes made
I have learned though reading up on dapagliflozin that it should not be used in patients older than 75, for those on loop diuretics or volume depleting drugs and those with an eGFR of < 60 (which is not unusual for my diabetics so its use will be limited). I will caution patients about side effects such as increased risk of hypos if taking gliclazide and potential for UTIs. I have seen hospital consultants using this drug and after discussion at a recent educational meeting, they are happy for GPs to start initiating it.

Section 2g: Audit in prescribing

There are innumerable audits that can be performed on prescribing. Some may be to do with safety and medicines monitoring, others may be to do with quality and prevention. Audits may identify cost savings or appropriate drug switches. A simple audit may be presented on a side of A4 and is just as appropriate as an 8 criterion COGPED standard audit though bare in mind that the latter would be required if being submitted as the sole Quality Improvement activity for a whole 5 year revalidation cycle.

Some suggested audits could be:-

Medicines monitoring and Safety

- Frequency of thyroid function testing in patients receiving Levothyroxine
- Regular blood monitoring in patients on Methotrexate
- Thyroid function testing in patients taking Amiodarone
- U&E testing on initiation of an ACE inhibitor

Quality or prevention

- Aspirin therapy in IHD
- Statin use in IHD
- Appropriate use of benzodiazepines
- ACE / AIIA in diabetic patients with micro albuminurea

Cost savings or appropriate drug switches

- Clopidogrel - appropriate usage
- Inappropriate generic use (eg MR calcium channel blockers or theophyllines)
- Use of enteric coated v. soluble aspirin

Section 2h: Significant event analysis

Significant event analysis if carried out correctly can be a powerful learning tool acting as a catalyst for change. A significant event may be defined as *"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice"* (Pringle et al 1995).

Significant events can be an event where something has gone wrong, where a less correct course of action has been taken or may be an example of where the system or an individual has worked well and the event is analysed in an attempt to ensure that the system will perform equally well should the same situation arise again. Two examples are given below, one a positive experience and the second, negative.

Significant events should not be used to apportion blame, rather, to foster an environment of openness and a willingness to examine practice and systems to improve services and safety.

Title of event
Date of event
Date of SEA meeting
Personnel present and role
Description of event
What went well?
What could have been done better?
Reflections on the event (consider Knowledge skills and performance· Safety and quality· Communication partnership and teamwork· Maintaining trust)
What changes have been agreed? (Personal or Team)
Changes carried out and their effect

Example

Title of event
Child with meningitis
Date of event
3/1/14
Date of SEA meeting
9/1/14
Personnel present and role
Drs A, B and C, practice manager, senior practice nurse
Description of event
At 8am on a Monday morning a mother rang the practice and requested a house call for her 8 year old child. The receptionist was alarmed by the symptoms described (headache and light hurting his eyes) and advised the mother to immediately bring the child to surgery. The child arrived 5 minutes later and was brought into my room immediately. A quick assessment showed this child to have meningism, in the meantime the receptionist alerted another doctor in the practice and the practice nurse. Penicillin arrived with the nurse and my partner made arrangements for hospitalisation, the nurse drew up the penicillin and I continued my clinical assessment.
What went well?
• *Receptionist training and experience, the receptionist was able to spot potentially serious symptoms and advise the mother of the best and quickest action* • *The immediate availability of two doctors to attend an emergency – this is mainly a reflection of working as a team* • *The receptionist summoning help including the penicillin* • *The availability of in date penicillin without having to search for it* • *Further evidence of teamwork in the multi tasking*
What could have been done better?
This is a very positive significant event – everything went well. We need to learn from this and ensure up to date resuscitation training for all staff. Of particular note the availability of emergency medication needs examination
Reflections on the event (consider Knowledge skills and performance· Safety and quality· Communication partnership and teamwork· Maintaining trust) *I was pleased that my clinical skills in spotting a case of meningitis had not degraded since hospital days and that I was able to give the recognised first line treatment at the correct dose (600mg of phenoxymethylpenicillin). The child had definite photophobia, was irritated, had a positive Kernig's sign and at least one petechiae on the upper left chest, also a CRT of > 2 seconds. I contacted the ward later that day and the child was stable on HDU.*
What changes have been agreed? (Personal or Team)
The practice nurse now has a list of emergency medication expected to be on site and up to date this is checked monthly as per a protocol.. The doctor's bags are checked and restocked monthly.

Changes carried out and their effect
The changes have been implemented in full. Monthly audits show that emergency medication is being checked and maintained as per the protocol as are the doctors' bags.

Example

Title of event
Mistaken identity and breech of confidentiality (giving out a patients address)
Date of event
17/1/14
Date of SEA meeting
1/3/14
Personnel present and role
All GPs, senior nurse, senior receptionist and practice manager
Description of event
A patient asked for his repeat prescription at the reception desk. He was handed a prescription for a patient with the same name (but different address). Fortunately this was noticed by the pharmacist prior to dispensing.

What went well?
Good relations with a vigilant pharmacist and their checking procedures are working well
What could have been done better?
*The main reason was not asking the patient for his name **and** address before giving the prescription out.*
Reflections on the event (consider Knowledge skills and performance· Safety and quality· Communication partnership and teamwork· Maintaining trust)
At a multi disciplinary meeting the issuing of prescriptions in general was examined, it was felt that the system for review of patients could be strengthened and that fewer of the receptionists would be involved in generating repeat prescriptions. *The specific issue highlighted the risk of mistaken identity and the importance of checking patient details until identity firmly established.*
What changes have been agreed? (Personal or Team)
The LHB are running some training days for staff involved in prescribing and rotas will be changed to involve only 3 receptionists in generating prescriptions. These 3 receptionists will attend the LHB course.
Changes carried out and their effect
A poster has been placed behind the reception desk that states "check name and address of patients collecting prescriptions, obtaining results or booking appointments. If unsure check date of birth" *The relevant receptionists are booked onto the LHB course*

Section 3: Communication, Partnership and Teamwork

Section 3a: Working with patients

Repeat prescribing

In this section demonstrating your relationship with patients it may be appropriate to find out how your patients feel about your repeat prescribing system. The questionnaire below could be used to canvass the views of 30-50 of your patients.

Once you have collected in the responses you should reflect on the scores and any comments. You may wish to include these reflections as an appraisal entry and retain the questionnaires as additional supporting materials.

Questionnaire for patients

Dear patient

The practice is examining its repeat prescribing system it would be helpful if you could complete this questionnaire and return it to ……. Your responses will be anonymous.

Please circle the most appropriate answer.

My prescription is always ready when I have been told it will be Agree Disagree 10 9 8 7 6 5 4 3 2 1
My prescription is always correct Agree Disagree 10 9 8 7 6 5 4 3 2 1
The doctor or nurse reviews my medication on a regular basis Agree Disagree 10 9 8 7 6 5 4 3 2 1
I know why I am taking all my medication Agree Disagree 10 9 8 7 6 5 4 3 2 1

Comments:

Thank you for completing this questionnaire.

Example of analysis of the above questionnaire

In general the patients seem satisfied with our repeat prescribing system – no serious problems were identified. What I did find surprising was that about a third of patients did not know why they were taking their medication. This is something the practice (and myself) should tackle at medication reviews.

Section 3b: Working with colleagues

Prescribing habits questionnaire

Although Practice Prescribing Report data gives an overview of the practice prescribing it is difficult (particularly in larger practices) to identify the prescribing habits of individuals. In this "working with colleagues" section it may be of value to ask others to reflect on your prescribing habits. You may wish to use the questionnaire below to help. You should obtain the feed back in an anonymous fashion perhaps by getting a third party to collect the returned forms. Other partners, local pharmacists and practice prescribing clerks would be appropriate people to ask to complete the forms.

Once you have collected in the responses you should reflect on the scores and any comments. You may wish to include these reflections as an appraisal entry and retain the questionnaires as additional supporting materials.

Questionnaire for colleagues

Dear colleague

I am currently examining my prescribing behaviour. I should be grateful if you could fill this form in and return it to …….. Please do not identify yourself on this form. If you cannot comment on a section please leave it blank.

Please circle the most appropriate answer.

This doctor appears to adhere to practice/local prescribing policies Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor makes few prescribing errors Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor seems to prescribe appropriately for chronic conditions (e.g. diabetes, IHD, asthma) Agree Disagree 10 9 8 7 6 5 4 3 2 1

This doctor does not seem to overuse antibiotics Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor uses hypnotics appropriately Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor keeps good records of prescribing including reasons for prescription Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor prescribes generically where appropriate Agree Disagree 10 9 8 7 6 5 4 3 2 1
This doctor is not overtly influenced by the drugs industry Agree Disagree 10 9 8 7 6 5 4 3 2 1
Comments:

Thank you for completing this questionnaire.

Example of analysis of the above questionnaire

The responses from my colleagues seem to indicate that I prescribe appropriately in chronic conditions and that I adhere to our practice formulary. There are no issues identified over my hypnotic prescribing and my generic prescribing is fine as I expected. A few of the respondents however see my antibiotic prescribing as less than perfect – one comment being "seems to prescribe antibiotics to about 50% of patients presenting with URTI". I am aware that I am a bit of a "soft touch" so I will look more closely at this and perhaps audit my consultations for a short period.

Section 4: Maintaining Trust

Use of new drugs – relationship with industry

In addition to the formal statements included in the online appraisal process, you may add further information to this section using the same forms as for the other sections, for example to illustrate ways in which you feel you have demonstrated insight into your probity.

There are many external influences on prescribing decisions, local formularies, local specialist use of medications, publications, advertising and drug representatives. You may wish to reflect on the extent to which external forces influence your prescribing. The questions below will help you to consider some of the key issues in this area. You may wish to include your reflections as an appraisal entry and upload the template below as supporting documentation.

1. **How soon after launch would you consider prescribing a new drug?**

Which statement is most accurate?	✓
I am likely to be one of the first to prescribe it	
I would normally prescribe after seeing the company representative	
I will wait until my colleagues in the practice have tried it in a few patients	
I will prescribe after I have seen local consultant colleagues use it in a few patients	
I will wait until it is commonly used or on local formulary	

2. **What is your policy about seeing drug reps?**

3. **What influence, if any, do drug reps have on your prescribing?**

4. **Do you accept hospitality from the Pharma industry? – if so to what degree?**

5. **Examine your answers above and reflect on any issues arising**

<u>Example</u>

Influences on prescribing

1. **How soon after launch would you consider prescribing a new drug?**

Which statement is most accurate?	✓
I am likely to be one of the first to prescribe it	
I would normally prescribe after seeing the company representative	
I will wait until my colleagues in the practice have tried it in a few patients	✓
I will prescribe after I have seen local consultant colleagues use it in a few patients	
I will wait until it is commonly used or on local formulary	

2. **What is your policy about seeing drug reps?**

I see reps after morning surgery on Thursdays by appointment only. I tend to see 2 or 3 each week

3. What influence, if any, do drug reps have on your prescribing?

I like to hear about the different formulations of medications and latest evidence that they produce in connection with their drug. I recognise this probably does influence my choice of drug within a class but I am aware of costs in this equation. I try to appraise the evidence presented but it is not always possible.

4. Do you accept hospitality from the Pharma industry? – if so to what degree?

I do occasionally go out for a meal with local reps and I also attend educational meetings sponsored by the industry. I have been on educational weekend meeting but not for a few years.

5. Examine your answers above and reflect on any issues arising

This exercise has made me think quite hard about what actually influences my prescribing, I had to think very hard whether or not seeing reps regularly had undue influence on my prescribing. I suspect that there is definitely some influence although I do not actively prescribe drugs in return for hospitality. I suspect the influence is over which drug I prescribe within a category. My generic prescribing is high but with many drugs not yet off patent that makes little difference overall to drug costs. I note I am quite an early adopter and I was aware of this, I do like to try new improved therapies to see if I can benefit my patients.

Overall I do not think I have issues of probity but I will in future be more aware of influences on my prescribing habits.

Section 5: Additional resources for Sessional GPs

It is recognised that many of the sections in this resource pack will not be suitable for Sessional GPs (freelance and salaried GPs), Practice Prescribing Report data is not available and, unless in a regular post, follow up of patients is difficult. Case reports will obviously be an appropriate method as would significant events. Suggested below is a review of prescribing that may be helpful

Safety and Quality section

Prescribing habits

Collect 20 consecutive consultation in which prescribing is an issue – this could be stopping or changing medication, a conscious decision not to prescribe or changing a dose or regimen.

Sex	Age	Diagnosis	Prescribing choice	Why did you choose this course of action

Learning points identified from these cases

Action to be taken/changes to be made

Example

Sex	Age	Diagnosis	Prescribing choice	Why did you choose this course of action
F	*3*	*Sore throat*	*Penicillin V 125mg qid*	*Chid was unwell some pus on tonsils*
M	*37*	*Back pain*	*Co-codamol 8-500*	*Acute back pain following lifting analgesia only*
M	*65*	*Diabetes*	*Increase metformin from 500 bd to 1000mg bd*	*Patient has HBa1c of 8.5 and is obese – increasing dose logical choice*
F	*44*	*Depression*	*Cipralex 10 mg od*	*New depression I know that Cipralex well tolerated*
M	*6*	*Sore throat*	*Penicillin V 125mg qid*	*Mum pressurised for antibiotics – child feverish*
F	*60*	*Hypertension*	*Increase Ramipril to 10mg od*	*Uncontrolled hypertension on 5mg Ramipril – I remembered to have U+E checked in a week*
F	*32*	*Cough*	*Advice only*	*Patient had 3 day history of non productive cough chest clear advice only*
M	*65*	*Chest pain*	*GTN spray aspirin*	*Anginal sounding pain infrequently given GTN as a therapeutic trial investigations instigated (ecg and bloods), aspirin given as a preventative until diagnosis established/refuted*
F	*4*	*Otitis media*	*Amoxycillin 125mg tid*	*Child in pain with fever mother wanted treatment*
M	*27*	*Dental abscess*	*Metronidazole 400mg tid*	*Unable to access dentist for 3 days had facial swelling and pain*
F	*19*	*Morning after pill request*	*Levonelle 1*	*Appropriate prescription also told to take the two at once – I picked this up on my recent contraception course*
F	*17*	*Anxiety*	*Propranolol SR 80 mg*	*Exam nerves – did not want to prescribe sedative drug*
M	*12*	*Asthma*	*Seretide 125mcg*	*Patient on salbutamol and beclamethasone (200 mcg bd) still symptomatic next step is to add a long acting b 2 agonist*
F	*2*	*Runny nose and cough*	*Amoxycillin 125mg tid*	*Had symptoms for 3 days with purulent nasal discharge – chest clear*
F	*56*	*Anxiety and depression*	*Diazepam 2mg (20 only given) cipralex 10mg*	*This lady was very anxious I therefore prescribed short term diazepam in addition to an anti depressant which should help long term*
M	*52*	*Hypertension*	*No prescription*	*This patient had borderline hypertension, I discussed the*
				options with him and he is going to try diet and exercise for 3 months – for follow up
M	*63*	*Stable angina*	*Increased dose of statin*	*This patient has chronic stable angina and a cholesterol of 5.6. evidence suggests that this should be lower I therefore increased the dose of simvastatin from 20 to 40mg*

F	*4*	*Sore throat red eyes*	*chloramphenicol eye drops, amoxicillin 125mg tid*	*Sticky eye red and red throat*
M	*2*	*Sore throat*	*Amoxicillin 125mg tid*	*Red throat brother of the patient above*
F	*35*	*Postponement of menstruation*	*Primolut N tds*	*Going on holiday in 2 weeks time wished menstrual cycle postponed*

Learning points identified from these cases

I was struck by the fact that I saw six children with infections in the twenty patients – probably a reflection of the time of year and the normal case mix I see as a locum. I prescribed antibiotics to all six and I am sure that is not the correct course of action. I also issued four prescriptions with proprietary names. I have used cipralex twice as my antidepressant of choice, I am aware that it is more expensive than other antidepressants. I have made some alterations to patients long term medications that I believe are appropriate and I have used the choice not to prescribe on two occasions.

Action to be taken/changes to be made

I think I need to look closely at my prescribing of antibiotics in children. I am aware that parental pressure can influence my choice to prescribe. I also need to prescribe generically where appropriate and think about my first choice antidepressant.