Audit and Prescribing Review

Guidance for sessional GPs

# Background

Although audit and prescribing review are *separate* topics, many doctors have undertaken a review of their prescribing which has taken the form of an audit. Prescribing review needs to be undertaken against acknowledged standards, and these are widely available. Examples are practice or local formularies, Health Board prescribing guidelines and SIGN guidelines. You might decide to use an audit of your practice against a published standard in one of these areas. (Examples 1 and 3 below)

Audit has become an established part of general practice training and is now a recognised tool for examining the effectiveness of clinical care. Ideally you will have been involved or contributed to the audit, but the most important thing is that you need to reflect as part of your appraisal submission what you have learned and demonstrate changes that you have made as a result.

It is recognised that sessional GPs may have difficulty in undertaking audit when they have no fixed practice base and are therefore unable to measure the effects of their care – for example in chronic disease management.

# Possible solutions

Using a log of some of your consultations can provide you with audit material. You can later repeat measuring similar consultation data to see whether any changes introduced after the first part of the audit have been effective.

## Example 1- Antibiotics (5 or 8 criterion audit)

As a sessional doctor you will often see a high proportion of patients presenting for unscheduled care with simple infections. Your prescribing will reflect this.

For **ten** surgeries, note your use of antibiotic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. Patients receiving antibiotics should have a recognised condition for which antibiotics are recommended
2. Antibiotics should be used which are in line with local formulary or microbiology laboratory recommendations for first line use, unless clinically contraindicated
3. When appropriate, microbiology sampling should be undertaken to check on organisms and sensitivities
4. All antibiotic prescribing should use the most effective dose and duration of treatment for the identified condition, in line with local formulary guidelines or the BNF.
5. All antibiotic prescribing should be accompanied by a check for known past history of hypersensitivity.
6. All antibiotic prescribing should be accompanied by a check for potential drug interactions.
7. Broad spectrum antibiotics should only be used where clinically indicated.
8. If a second line antibiotic is used, the reason for its use should be documented.
9. All potentially infective lesions or conditions should be subject to local infection control policies.
10. Patients with MRSA should be handled in line with agreed local guidelines.

These are only examples of criteria which you might choose from. You are recommended to use criteria which **you** can justify, and you will then need to justify the standards that you set for your performance. You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the “audit cycle”.

## Example 2- investigation and imaging (5 or 8 criterion audit)

Sessional doctors as a group generate a high rate of investigation and imaging requests. This is not necessarily a criticism, since a sessional doctor may see a case mix which includes fewer patients attending for review.

You may also feel the need to practice more defensively without the opportunity for follow up or “watchful waiting”. However, it may be helpful to audit your use of investigations as a way to review their effectiveness.

For **ten** surgeries, note your use of investigations and imaging requests. You should keep a note of each patient, and at a later date you should

* either contact the practice to find out the result
* or contact the laboratory or X-ray department

You can the audit against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. A request for a laboratory test should have a clear clinical reason. Can you identify one for each of yours? (For example, if checking renal function in hypertension, what reason for also ticking LFTs?)
2. Laboratory samples need to be correctly labelled, in the correct container and to arrive timeously. (Were all of yours?)
3. A laboratory investigation should be appropriate. On reflection did you ask for a test that was likely to help with managing the patient’s problem? (For example, it is difficult to justify checking TFTs for a young patient who complains of “tiredness all the time” whose TFTs were checked three months ago)
4. Investigations should expect to include a reasonable proportion of abnormal results. (What proportion do you think this should be?)
5. Clear directions should be included on a request form if a telephone report is required. Did you do this?
6. X-rays should only be requested in compliance with the guidelines of the Royal College of Radiologists (to avoid unnecessary exposure to ionising radiation). Do you know what this states or how to find out?
7. Guidelines now suggest alternatives to X-ray investigations in some cases: did you follow all relevant guidelines? (for example, SIGN or local guidelines on dyspepsia)
8. Radiologists now have the right to refuse all requests which do not conform to guidelines. All requests for which the referring doctor is uncertain should be discussed before referral. Did you encounter a situation like this?
9. All imaging techniques have limitations. Can you show that your requests take this into account? (For example, an ultrasound scan on a “lump” can only be performed on one that you can definitely palpate)
10. Some imaging investigations can be dangerous or uncomfortable. Do you give patients a clear explanation and explore possible adverse events in advance? (Barium enema or colonoscopy are both uncomfortable and sometimes hazardous: allergy to injected contrast medium may be serious: diabetics who are asked to fast before an examination need special arrangements)

These are only examples of criteria which you might choose from. You are recommended to use criteria which you can justify, and you will then need to justify the standards that you set for your performance.

You may find it helpful to contact a local laboratory or X-ray department for some advice on what criteria to choose. Many departments are now able to provide you with feedback on your use of their services if you have made the request with a name or identifier which is unique to you.

You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the “audit cycle”.

## Example 3. Prescribing for pain. (5 or 8 criterion audit)

As a sessional doctor you will often see a high proportion of patients presenting for unscheduled care with painful conditions. Your prescribing will reflect this.

For **ten** surgeries, note your use of analgesic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. Patients prescribed analgesics should have a condition or reason clearly recorded in their records
2. Analgesics should be used which are in line with local formulary recommendations for first line use, unless clinically contraindicated
3. If a non-steroidal anti-inflammatory is used, gastric protection should be considered where appropriate (for example elderly, debilitated patients)
4. Non-steroidal anti-inflammatory drugs should generally be avoided in patients with a past history of GORD, ulcer disease or upper G-I haemorrhage
5. Strong analgesics should be prescribed in relatively small quantities on first presentation (a week?)
6. Patients with chronic pain should have a clear record of any adjustment to their regime
7. Patients who are prescribed opiates often experience constipation: for elderly patients a laxative should be prescribed or a warning of the risk given to the patient and recorded
8. All analgesic prescribing should be accompanied by a check for known past history of hypersensitivity.
9. All analgesic prescribing should be accompanied by a check for potential drug interactions.
10. If a second line analgesic is used, the reason for its use should be documented.

As an alternative you could audit your personal handling of controlled drugs:

1. Your controlled drug register should contain details of all controlled drugs that you hold (Class A)
2. Your injectable Class A drugs must be in a locked case or bag
3. You have details of how to contact the appointed officer responsible for disposal of expired or redundant Class A drugs
4. Your prescriptions for controlled drugs all meet the regulations (you will need to log these prescriptions or take copies prospectively for this criterion)
5. No prescriptions for controlled drugs should exceed one month’s supply

These are only examples of criteria which you might choose from. You are recommended to use criteria which you can justify, and you will then need to justify the standards that you set for your performance.

You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the “audit cycle”.

**If you are unable to undertake these preferred options**, you could use the tools below for reflective learning with your appraiser.

# Appendix 1: Management Plan Proforma (Audit)

*Boxes will expand as you type.*

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| --- |
| Clinical Management Plan*Describe a management plan, referenced to a specific written, national or local protocol, which you have used in the management of a patient with chronic disease in your clinical practice. Your management plan should clearly illustrate compliance with the guidance.* |
| Management Plan: |
|  |
| Please indicate for this patient where you used your guidelines/evidence base in their management plan: |
|  |
| Name: | **Signed:** | **Date:** |
|  |  |  |

# Appendix 2: Clinical Case Report Proforma (audit or prescribing)

*Boxes will expand as you type.*

|  |
| --- |
| Clinical Case Report*Select one problem or random case from your normal surgeries for reflection and analysis.* |
| Explain why this case is clinically significant for you: |
|  |
| What decisions did you take in relation to this case and why? |
|  |
| What thoughts or reflections do you have in relation to this case? |
|  |
| What learning points have emerged from this case for you? |
|  |
| How will this learning be used in future? |
|  |
| Supporting case record available? (Y/N) |
|  |
| Name: | **Signed:** | **Date:** |
|  |  |  |