August 2020

**Self-Assessment Prescribing Review for GP Trainees- August 2020**

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**Self-Assessment Prescribing Review for GP Trainees**

**Background to the self-assessment prescribing review**

Prescribing is an integral part of work as a GP with over one billion prescription items being issued each year. However, prescribing errors in both primary and secondary care have the potential to cause significant morbidity and mortality. The GMC PRACtICe study identified prescribing errors in around one in twenty prescriptions(Avery et al., 2012). The study highlighted that, as a group, GP trainees may benefit from further support in prescribing.

Further to the PRACtICe study, one of the educational interventions considered was an individualised review of GP trainee prescribing. After positive feedback, this review process was undertaken as a pilot study in the East Midlands, called the *100 prescription study* (REVISIT), using a primary care pharmacist to undertake the review of approximately 100 consecutive prescription items prescribed by ten GP trainees in practice. The main aim of the *100 prescription* *study* (REVISIT)was to provide feedback and education in order to improve prescribing and introduce good practice in the early stage of the GP trainee’s primary care career so that these skills might remain in the long term.

The *100 prescription* *study* (REVISIT) has been reviewed and the process is thought to be useful. However, GP trainees may not be able to have a pharmacist support a review of their prescribing which has led to the development of the following material to support GP trainees reviewing their own prescribing.

The *100 prescription* *study* (REVISIT) identified prescribing events: prescribing errors, sub-optimal prescribing, legal errors and also examples of good prescribing.

An RCGP pilot of this prescribing assessment for full time ST3s in August 2019 reviewing 60 prescriptions found that 71.5% uncovered a prescribing error and 98.5% found at least one incident of sub optimal prescribing. The mean prescribing error rate and suboptimal prescribing rate calculated was 8.3% and 40.6% respectively. 90.2% of trainees, reported that completing the assessment altered their prescribing practice and 56.4% of trainers mentioned that the assessment highlighted knowledge gaps and areas for improvement for their trainee that they were not aware of. Most of the trainees and trainers agreed or strong agreed that the prescribing review was helpful for assessing and learning about prescribing and was viewed by both as an acceptable prescribing assessment.

**Definition of prescribing error**: A prescribing error occurs when, as a result of a prescribing decision or prescription-writing process there is an unintentional, significant reduction in the probability of treatment being timely and effective or increase in the risk of harm when compared to generally accepted practice.

**Suboptimal prescribing**: these are prescribing problems that do not fit the above error definitions but represent less than ideal practice.

**Legal error:** This type of error is where a prescription has not met the legal requirements for prescribing. Examples of this include:

* Medication intentionally prescribed for one patient against another patient’s name such as a family supply of head lice treatment given on a prescription for a child.
* Prescribing more than 30 days’ supply of a controlled drug without a clear and valid reason.

**Aims of the self-assessment prescribing review**

In the main, this exercise is meant to be formative. This means that the emphasis is on using the review to facilitate reflection by the trainee and providing material for feedback from the Clinical Supervisor. However, there is also a summative element to the exercise. This means that the review is mandatory and not optional. It also means that if, in the opinion of the Clinical Supervisor, the Educational Supervisor, or an ARCP panel, the exercise has not been undertaken with sufficient reflection or without meaningful learning with respect to prescribing, the trainee might be asked to repeat the review.

It is important to note that no ratings are being applied to this element of Workplace Based Assessment. The prescribing standards of the trainee are not being graded as such. All doctors make prescribing errors from time to time although thankfully serious errors are uncommon (approximately one in 550 prescriptions in the PRACtICe study). It is not the rate of errors or sub-optimal prescribing that is important but the way in which the trainee responds to them. However, a self-assessment that does not identify any errors or suboptimal prescribing and therefore no learning points would not be acceptable given that this was never the case in the PRACtICe or *100 prescription* (REVISIT) studies.

**Overview of the GP Trainee led prescribing review**

* Start of data collection period will be chosen by clinical supervisor
* GP trainee will not know the start date in advance

**GP Trainee led review prescribing review**

In order to capture normal prescribing habits, the review is retrospective with a start date provided by the GP trainer that the GP trainee is not aware of in advance. The GP trainee then either:

1. Reviews consultations on the start date before working backwards in time until at least 50 prescription items have been identified for review (these are referred to as ***prescribed prescription items)*** or:
2. The trainee runs a computer search to identify the last 50 prescriptions and adds them to the spreadsheet. A computer search is available for most clinical systems.

The prescribed prescription items should have been issued in consultation (either as a telephone or face to face consultation). The prescribed prescription item could be a:

* New acute (NA)– acute item never prescribed before
* Repeat acute (RA) – acute item that has been repeated from the medication history screen.
* New repeat (NR) – new item added to repeat
* Repeat repeat (RR) – item prescribed from the current repeat screen

The clinical system searches provided as part of this assessment vary slightly depending on the clinical system in use and may not collect data from all of these categories.

More than one item may be issued during a single consultation and these may be different prescription types e.g. a ‘new acute’ and a ‘repeat repeat’.

Prescribing that is included in the review:

* Any prescribing where there has been a patient consultation in a clinic setting either face to face or by telephone. The GP trainee must also have issued and signed (by hand or electronically) the prescription themselves.

Prescribing that is not included in the consultation review but may occasional arise in the computer search review are:

* Prescriptions issued during paperwork review without consultation with the patient e.g. processing of letters from secondary care
* Items that are for “personal administration” in the practice e.g. vaccinations, IUD.
* Signing prescriptions issued by other members of the practice team e.g. reception or nursing staff

Responding to requests made by patients via the repeat prescription service or via reception.

When a prescribed prescription item is identified, each item should be considered in detail by considering the following questions:

1. Was the **RIGHT DRUG (s)** selected for the indication and the patient?
2. Was the drug prescribed at the **RIGHT DOSE** for the indication and the patient?
3. Were the **RIGHT DOSAGE INSTRUCTIONS** written on the prescription in a way the patient can understand?
4. Was the **RIGHT FOLLOW UP** planned, enacted or acted upon with regards to the medication?
5. Have you provided the **RIGHT DOCUMENTATION** to support prescribing?
6. Has the medication been subject to the **RIGHT REVIEW** before prescribing (including checking adherence to therapy)?
7. Are there any examples of **GOOD PRESCRIBING** practice?

A checklist for each of these areas is provided to assist with the reviewing process (see appendix 1). Examples of errors found in the *100-prescription study* (REVISIT) are provided in Appendix 2.

More than one error may be identified when a medication is reviewed e.g. a ‘right drug’ error and a ‘right documentation error’. When reviewing prescribing, if the medication prescribed was identified as being the incorrect medication but in relation to that drug all other categories are correct then only one error, a ‘right drug’ error, is coded. If a medication is prescribed that would not have been a first line choice (or even in the guidelines) but there is sound clinical reasoning documented, then this would NOT be classed as an error.

When a prescribing event has been identified the GP trainee should consider:

* The possible reasons why the event occurred.
* Possible methods to avoid the event happening in the future.
* How they will check that the methods they have tried are working.

The examples provided in Appendix 2 breakdown the prescribing events into prescribing error and sub-optimal prescribing. The reviewer may find it useful to consider whether an event is a prescribing error or sub-optimal prescribing based on the definitions provided above. However, the classification is not as important as reflecting on the reasons it has occurred and possible avoidance strategies.

**What might the review identify?**

The *100-prescription study* (REVISIT) identified areas where prescribing could be improved in all participants and therefore this review is likely to highlight the same. Making small changes to prescribing habits may help protect a prescriber from making prescribing errors in the long term. This prescribing review is intended to be educational and supportive to the prescriber. Reviewing the prescribing events will identify possible strategies that could be put into place to improve prescribing in the future. How these strategies can be incorporated into everyday practice and become long term prescribing habits should be identified.

The review will also highlight areas of good prescribing practice that you will want to make a conscious decision to continue with because you have identified them as contributing to safe prescribing. This aspect is just as important as highlighting areas for improvement.

When the results are reviewed it is important to look for themes and patterns either in the type of error or the BNF category. It may also be useful to review the breadth of prescribing across the categories and consider whether current prescribing reflects the variation that would be expected of a qualified GP.

If a prescribing error is identified as part of the review, the possibility of actual patient harm should be considered. If appropriate, the GP trainee should highlight the incident to their clinical supervisor immediately and follow the practice procedure for managing prescribing errors.

**Preparing for the review**

When undertaking self-review, it is useful to have all the reference sources that you will need open either in paper form or in your computer browser. Examples include:

* BNF and BNF for children
* Local formulary guidance
* Local clinical guidelines e.g. antimicrobial guidelines
* This handbook (especially appendices 1 and 2)

Try not to presume that your knowledge of a medicine is correct even though you may prescribe it frequently. To ensure that you have complete and current knowledge, undertake a second check in a reference and consider reading around the monograph to refresh your knowledge. When checking antimicrobial dosages with the local antimicrobial guidelines be careful to check indication, allergy status, place in therapy and course length as well as dosage. When reviewing documentation, try and imagine that you are looking at the notes for the first time and do not have prior knowledge about the patient. You may remember why you prescribed an item and be able to explain the rationale but if this reason is not clear in the notes then the issue should be highlighted in the review.

**Using the Excel spreadsheet**

An Excel spreadsheet is provided to help you undertake the review and reflect on the results. If a search has been run on the clinical system, it may be possible to copy and paste the relevant information into the review spreadsheet. A trainee may choose to create their own way of collecting and reviewing their data, but the review must cover and document the same areas.

The Excel spreadsheet provided can be broken down into three sections. The first section contains columns to enter the prescribing that has occurred. If you have used a clinical system search provided with this assessment, the report created should match the spreadsheet i.e.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Prescription number 1-50 | Patient number | Age  | Issuing user name  | Date of issue  | Medication | Dosage (as written) | Quantity | Linked problem  | If linked problem not completed or inaccurate, condition for which medication was issued |

The second section helps to review prescribing by considering each of the categories. If an issue is identified, place a number 1 in the column on the spreadsheet (otherwise enter a 0). Ensure that the last column of this section is completed to detail what should have been done and why e.g. dose should have been 500mg as per local antimicrobial guideline. Make sure you identify the good prescribing that is occurring as well.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Right Drug  | Right Dose  | Right Dose Instructions | Right Follow up | Right Documentation | Right Review | Good prescribing | Description of prescribing issues identified |
| prescribing error | suboptimal prescribing | prescribing error | suboptimal prescribing | prescribing error | suboptimal prescribing | prescribing error | suboptimal prescribing | prescribing error | suboptimal prescribing | prescribing error | suboptimal prescribing |

The third section asks the reviewer to reflect on the possible reasons as to why the issue occurred (or in the case of good prescribing was it a considered action and what was the reason). It also asks the reviewer to look at possible strategies that could be used in the future to prevent the issue occurring again (or in the case of good prescribing, is it already a habit or how can it be embedded). This section is essential. A review that only looks at the number of issues found will not be acceptable.

This spreadsheet will help when analysing the results and can be used to complete the table in the prescribing assessment forms (see appendices 3 and 4).

**Analysing the results of the prescribing review.**

The results can be analysed in various ways and the spreadsheet provided can be manipulated to help you achieve this. Whilst the individual prescribing events have been reviewed the data should also be viewed as a whole. It is important to look for trends or themes in prescribing that the reviewer can highlight as good prescribing areas or areas that could be improved. As each review will highlight different aspects, the following are questions that could be considered as part of the evaluation.

* How many prescribing events have been highlighted by you?
* Were there any themes that could be identified within these prescribing events?
* Which areas of good prescribing did your review identify?
* What was the number of prescribing events in each of the prescription categories (new repeat, repeat repeat etc.)?
* What was the number of prescribing events in each of the prescribing event categories (right drug, right dose etc.)?
* Are there any prescribing events that have occurred more than once (e.g. incorrect dose of an antibiotic)?
* Are there examples of good prescribing that have occurred more than once?
* When the possible reasons and possible strategies for the future are considered are there recurring themes e.g. need to refer to guidelines, need to document indication. How can this then link to your personal development plan?
* Which areas of the BNF cover the majority of the prescribing (e.g. antimicrobial and analgesia)? Would your clinical supervisor consider this typical of current prescribing and that of a post CCT GP?

**Additional notes for clinical supervisors**

* At least 20 prescribed items need to be reviewed by the clinical supervisor. These will be identified from the patient names on the original search that will be provided by your GP trainee. The spreadsheet will suggest random patients to review or patient names can be chosen randomly from the list and should ideally be taken from various times and dates included in the review period. Selecting patients where errors have not been highlighted by the trainee are particularly important to check that errors have not been missed.
* In the time frame of the review, no prescribed items should be skipped or omitted from the review by the GP trainee if they have met the criteria for inclusion.
* You are encouraged to complete a copy of the same spreadsheet as the GP trainee. Areas for improvement and good prescribing practice can be identified although it may be difficult to complete the section relating to the possible causes.
* The results should be compared to the GP trainee’s results for the same patients. If there is a discrepancy in the results, then reviewing a few more items may be necessary to make a judgement on the quality of the review. The trainee needs to be assessed against and to reflect on their performance against the GP Prescribing Proficiencies below:

**GP Prescribing Proficiencies**

All prescribing GPs are expected by GMC (GPC 2017) to demonstrate the following across a range of ages and covering different clinical areas:

* Assess the risks and benefits including that posed by other medications and medical conditions.
* Identify when prescribing unlicensed medicines and informs patients appropriately.
* Adhere to local guidelines and evidence-based medicine.
* Use antimicrobials appropriately.
* Counsel patients appropriately including instructions for taking medicines safety in line with up to date literature.
* Review and monitor effects including blood testing at appropriate intervals.

At the end of the assessment the trainer needs to make a judgment on the overall level of proficiency of the trainee to make a judgment and to select one of the following:

**This assessment demonstrates the trainee is currently *[Please highlight one of the following]:***

* A safe, reflective GP prescriber at this point in time ☐

*[It is still expected that they have PDPs to further improve their prescribing]*

* Needs to develop specific prescribing skills to fulfil the prescribing proficiencies☐
* Needs support and educational input prior to repeating all of this assessment☐

**Appendix 1 - GP Trainee prescribing review checklist**

|  |  |
| --- | --- |
| **Prescribing area** | **Areas to consider** |
| **Right Drug** | * Evidence for use in the indication
* Allergies
* Contra-indications/Cautions
* Interactions with co-prescribed medication
* Local and national prescribing guidelines
* Local formulary
* Social issues (e.g. carers, inclusion in a monitored dosage system)
* Formulation
* Duplication or omissions in therapy.
* Correct use of brand prescribing for safety reasons
 |
| **Right Dose** | * Renal or hepatic function
* Age / weight
* Local and national prescribing guidance (including MHRA)
* Is the dose correct for the indication?
* Has increasing or reducing dosing been done appropriately?
* Most appropriate strength of tablet prescribed for the required dose.
 |
| **Right Dosage Instructions** | * Clear and unambiguous (avoiding “as directed”)
* Up to date (according to current usage/latest letters)
* Include route of administration/area of application/treatment eye or ear
* Are the instructions able to be read and understood by the patient?
 |
| **Right Follow-up** | * Has the necessary monitoring been planned/taken/acted upon e.g. blood tests, BP.
* Has the item been placed on repeat appropriately so that it cannot be continued without a necessary review?
 |
| **Right Documentation** | * Is the indication for prescribing clear and relevant?
* If prescribing does not follow standard guidance is the reason documented?
* Is the plan for any necessary monitoring or follow up documented?
 |
| **Right Review** | * Where the medication has been used before, has under or over-ordering been addressed before supplying (adherence to therapy)?
* Have any necessary discussions taken place before continuing medications with risks e.g. HRT?
 |
| **Good prescribing** | * Does prescribing show that local guidelines have been referred to e.g. antimicrobial guidelines?
* Is the prescribing plan in the notes and thought process accurate and clear for the next clinician to follow?
* Is the OTC advice that has been given very clear with regards to medication dosage and further advice?
 |

**Appendix 2 – Examples of prescribing error and suboptimal prescribing found in the PRACtICe study and 100 prescription study (REVISIT)**

**Right Drug**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Incorrect drug chosen for clearly documented current clinical requirements. Includes all forms of medication. *Example: a) Hydrocortisone butyrate cream selected for use on child's face instead of standard hydrocortisone cream. b) Gabapentin prescribed first line for musculoskeletal pain.* | Prescription of a second line antimicrobial therapy according to local antimicrobial guidelines without documentation to explain choice*Example: Second line H. Pylori eradication treatment regimen prescribed.* |
| Incorrect drug prescribed when stepping up or down therapy according to guidelines.*Example: Clenil started as a first line treatment for someone with possible COPD*  | Prescribing a topical medication for an unlicensed indication where the possibility of harm from the product is likely to be low and alternatives are possible*Example: Ibuprofen gel for head injury resulting in headache*  |
| Prescription of a medication that is not clinically required and the evidence in the documentation is clear.*Example: Helicobacter eradication treatment prescribed to a patient who is Helicobacter negative.* | Prescription of an opioid analgesic when a non-opioid would have been more appropriate but the risk of harm is low. *Example: Tramadol prescribed alone for biliary colic when NSAID was an option* |
| Prescription of a drug where an allergy to that drug has been recorded and the prescriber documents no reasonable acknowledgement/justification in the clinical record.  | Prescription of a restricted topical antimicrobial agent against local antimicrobial guidelines (but national guidelines suggest prescribed product)  |

**Right Drug (continued)**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Prescribing a medication that interacts with a currently prescribed medication and prescribing could and should be avoided and there is no clear and defensible justification.  | Failure to prescribe the formulation of a medication recommended by secondary care/specialist although the likelihood of harm or a deleterious effect on the patient is low *Example: Topiramate sprinkles recommended by neurology for migraine due to difficulty with tablets but tablets re-prescribed (note: if indication was epilepsy this would be an error).* |
| Failure to add a concomitant therapy to that would reduce the risk of harm from the item prescribed *Example: failure to prescribe gastro protection when prescribing an NSAID to a patient at high risk of GI bleed.*  |  |

**Right Dose**

|  |  |
| --- | --- |
| **Prescribing Error** | **Sub-optimal prescribing event** |
| Prescribing of a medication above the standard recommended dose (adult or child) at a dosage that is likely to cause harm (Unless a clear and defensible justification has been given by the prescriber or in correspondence from secondary care).*Example: Colchicine 1 four times a day for 4-5 days with no maximum dose of 12 tablets per course stated.* | Prescribing of a medication above the standard recommended dose (adult or child) but at a dosage that is unlikely to cause harm. (Unless a clear and defensible justification has been given by the prescriber or in correspondence from secondary care). *Example: High dose PPI prescribed when a lower dose would be clinically effective* |
| Prescription of a medication below the standard recommended dose where there is likely to be moderate to severe harm/ the risk of treatment failure is moderate/high or the dose is likely to cause a deleterious effect on the patient in terms of lack of control of symptoms. | Prescribing of a medication below the standard recommended dose where the risk of harm is low/ the risk of treatment failure is low or the dose is unlikely to cause a deleterious effect on the patient in terms of lack of control of symptoms.*Example: Calcium tablets prescribed at lower than the recommended dose for osteoporosis.* |
| Failure to act on a suggested dose change or recommendation from secondary care/specialist correspondence, where that dose change was aimed at either increasing therapeutic benefits or reducing risk of harm.  | Prescribing a strength of medication where more than one dosage unit is needed to supply the required dosage when a higher strength exists. (unless there is an obvious cost-saving motive or clinical reason) *Example: Estradot® patches 2x25mcg when a 50mcg strength is available.* |
| Under dosing of oral antimicrobial agents according to local and national prescribing guidance (e.g. BNF)*Example: Amoxicillin 250mg three times a day for an 8 year old child* | Prescribing a dose of antimicrobial agent that is lower than the local guidance but is still within the dose range within the BNF (if the dosage is below that recommended in the BNF then is an error)*Example: Erythromycin 250mg four times a day in an adult.* |
| Change of dose intended in notes but not prescribed/amendments made to medication and the risk of harm or effect on treatment is moderate to high. *Example: Consultation notes state increase dose of gastro protection due to symptoms but dose increase not made.* | Change of dose intended in notes but not prescribed/amendments made to repeat medication but risk of harm or effect on treatment is low.*Example: planned reduction in SSRI (not due to side-effects) not undertaken* |

**Right Dose (continued)**

|  |  |
| --- | --- |
| **Prescribing Error** | **Sub-optimal prescribing event** |
| Prescribing a product that is required to be taken at a certain time of day for increased effectiveness without stating the time of day on the instructions.*Example: Simvastatin prescribed to be taken daily rather than at night* | Failure to add a specific administration time to a medication that would be preferred to avoid possible side-effects or inconvenience to the patient (If this could reduce effectiveness it is an error.)*Example: Oral corticosteroids prescribed as daily rather than in the morning* |
| Prescribing the correct medication at a dose for the wrong indication and the dose is likely to reduce the effectiveness of treatment.*Example: Aciclovir prescribed at the dose for cold sores with a diagnosis of shingles* | Prescribing the correct medication at a dose for the wrong indication but the dose is unlikely to reduce the effectiveness of treatment or substantially increase the risk of side-effects |
| Prescribing of an oral antimicrobial agent for significantly longer or shorter duration that would be advised in national (e.g. BNF) or local antimicrobial guidelines*Example: Intentionally prescribing a seven day course of antibiotics for prostatitis* | Prescribing of an oral antimicrobial agent for a slightly longer or shorter duration than the local antimicrobial guidelines.*Example: Clarithromycin prescribed for 7 days instead of 5 days for ear infection* |
| Prescribing medication at a frequency below or higher than that recommended by the BNF/BNFC or SPC where there is moderate to high potential for harm.*Example: Betnovate cream prescribed too frequently in an adult* | Prescribing medication at a frequency below or higher than that recommended by the BNF/BNFC or SPC where there is low potential for harm *Example: Mild hydrocortisone cream in an adult.* |
| Prescribing a drug that interacts with a concomitant drug so that a reduction in dosage should be made but has not been.  |  |
| Failure to titrate or convert opioid medication appropriately and safely. *Example: converting from codeine to morphine resulting in an unintended dose increase.* |  |

**Right Dose Instructions**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Using "as directed" as the only dose instruction on medication with a moderate to high potential for harm (note: this does not include warfarin)*Example: Oral corticosteroids, any paracetamol prescription for a child, all controlled drugs (with the exception of scenario in low harm)* | Using "as directed" as the only dose instruction on medication with a low potential for harm .*Examples: Emollients when they are the only topical therapy, GTN sublingual tablets/spray prescribed, Benzodiazepines or anxiety for use pre-flight or similar where the quantity is ≤ 5 tablets and the strength is low (e.g. 2mg diazepam)* |
| Ambiguous or unclear dosing instructions for a medication with moderate to high potential for harm*Examples: Nortriptyline prescribed as: 2 TABLETS NIGHT/DAY, Propantheline prescribed as "four times daily max" , Strong opioids with inadequate dosage instructions including not having a maximum frequency on PRN doses*  |  Ambiguous or unclear dosing instructions for a medication with a low potential for harm. *Example: Topical preparation prescribed with dosage instructions implying an oral route for administration, e.g. take one twice daily. Salbutamol prescribed PRN without the number of doses to be taken* |
| Eye drops for glaucoma/ that contain steroids/ for non-serious eye conditions that will involve multiple carers prescribed without clear directions as to the eye for administration. | Eye drops (for non-serious symptomatic conditions such as conjunctivitis or dry eye) prescribed without indicating which eye the drop should be used in but the patient is capable of unsupervised self-administration. |
| Ear drops that will involve administration by multiple carers prescribed without clear directions as to the ear for administration. | Ear drops prescribed to a patient that is capable of unsupervised self-administration without stating the treatment ear  |
| Ear or eye drops to any patient prescribed without stating a frequency of use | Two or more topical steroid creams of different potencies prescribed for the same indication with no indication of where to use the different creams.*Example: Eumovate and hydrocortisone co- prescribed without stating application area on the directions* |

**Right Dose Instructions (continued)**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Drops that can be used in more than one route e.g. Eye/ear or eye/ear/nose without specifying where to use them*Example: Sofradex eye/ear drops* | Failure to update the dosage on a prescription to the current dosage taken by the patient and acknowledged in the clinical notes or an initiation dosage is repeated on further prescriptions.*Example: Gabapentin prescribed with the same initiating and increasing dose instructions on further prescriptions for the patient* |
|  | The prescribing of a dosage in terms of mg/mcg rather than the amount to be taken,*Example: Take 125mg of amoxicillin 125mg/5ml rather than take one 5ml spoonful* |

**Right Follow Up**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Monitoring not requested.*Example: a) Not responding to a request from secondary care to undertake laboratory test monitoring where this request is justified in terms of risks from the medication the patient is taking. b) Increasing the dose of an ACE inhibitor/ARB antagonist without checking U&E within three weeks.* | Monitoring not requested.*Example: Failure to do a digoxin level for a patient who has not had one done for a number of years and whose renal function has reduced but there are no clinical symptoms of overdose.* |
| Prescribing of a long term antimicrobial agent for an active infection without a clinical review.*Example: Continuing Terbinafine on repeat for longer than clinically required.* |  |

**Right Documentation**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Prescription of a drug with a moderate to high potential for harm without documented evidence of an indication for the drug.*Example: strong opioids, diazepam* | Prescription of a drug with a low potential for harm without documented evidence of an indication for the drug. (including where the read code in the consultation does not match the medication issued) *Example: Nasacort issued in a consultation for a three-day history of a cough with no mention of a blocked nose.*  |
|  | Prescribing medication as a handwritten script e.g. at a home visit and documenting the issue in the clinical notes but not adding the medication to the medication screens on the computer. |
|  | Failure to add or remove sensitivities/allergies from the clinical computer system as they are identified. |

**Right Review**

|  |  |
| --- | --- |
| **Prescribing error** | **Sub-optimal prescribing event** |
| Failing to undertake the required review on a medication where the harm is likely to be moderate of severe. *Example: HRT prescribed for a 60-year-old woman. Nil in notes to say continued use and risks had been discussed. Last reviewed 1 year ago so review now due.* | Failing to undertake the required review on a medication where the harm is likely to be low.*Example: Patient taking Marvelon® with no checks in place for 15 months.* |
| Failure to identify poor adherence or over ordering to medications when the risks to the patient are moderate to high*Example: asthma patient collecting LABA regularly without ICS* | Failure to identify poor adherence or over ordering to medications the risks to the patient are low. *Example: Patient collecting ICS inhaler regularly but not LABA*  |
| Failure to consider changes to guidelines that mean the patient is on less effective treatment than currently recommended.*Example: Aspirin prescribed alone for CVA with no documentation to support more effective therapies have been considered* |  |

**Good Prescribing**

|  |
| --- |
| **Examples of good prescribing** |
| Prescribing a second line therapy with clearly documented clinical reasoning |
| Prescribing a medication with a complicated regimen with very clear details of when to take the medication and the indication to support adherence |
| Identifying and addressing nonadherence |
| Documenting appropriate OTC medication advice to be used alongside the prescribed medication |
| Correctly converting formulations that require a change of dosage e.g. digoxin tablets to liquid |
| Using local guideline or formularies correctly to direct prescribing |
| Correctly identifying a clinically relevant drug interaction and amending prescribing to adjust for this |
| Prescribing multiple topical medication and ensuring indications and application sites are included in the dosage instructions |
| Simplifying a medication regimen to aid adherence |
| Correctly identifying and advising patients on when to take medication that interacts with food |
| Correctly identifying a change in dose/medication required due a change in renal function/age/weight etc |

**Appendix 3 – Trainee prescribing reflection form**

**Trainee prescribing reflection form**

**GP Prescribing Proficiencies**

All prescribing GPs are expected to demonstrate the following, across people of all ages which includes extremes of age, for example babies, children and older people with frailty (based on the GMC GPCs 2017):

1. Assesses the risks and benefits including those posed by other medications and medical conditions, reducing polypharmacy where possible.
2. Identifies when prescribing unlicensed medicines and informs patients appropriately.
3. Adheres to national or local guidelines (including recommendations for over the counter prescribing (OTC) and evidence-based medicine.
4. Uses antimicrobials appropriately.
5. Counsels patients appropriately including giving instructions for taking medicines safety in line with up to date literature.
6. Reviews and monitors effects including blood testing at appropriate intervals.

**Prescribing trainee assessment reflection**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number ofPrescriptions | Prescribing error | Suboptimal prescribing |
| Number scripts reviewed |  |  |  |
| “Right Drug” |  |  |  |
| “Right Dose” |  |  |  |
| “Right Dose Instructions” |  |  |  |
| “Right Follow Up” |  |  |  |
| “Right Documentation” |  |  |  |
| “Right Review” |  |  |  |
| OTC |  |  |  |
| **Total of all errors/suboptimal** |  |  |  |

I confirm that I have completed a review of 50 of my prescriptions in line with the RCGP WPBA prescribing assessment guidelines and have attached my anonymised spreadsheet of results to this log\*

Reflect with reference to the GP Prescribing Proficiencies outlined above.

What do you plan to maintain with regard to your prescribing?\**[Reflect on what you are doing well]*

What do you plan to improve with regard to your prescribing?\*  *[Consider how to improve your suboptimal prescribing]*

What do you plan to stop with regard to your prescribing?\* *[Comment on any significant errors]*

Which of the GP prescribing skills listed above have you not covered (if any) in this assessment? How will you address these?\*

Using your reflections above complete the following PDP(s):\* [creates a mandatory draft PDP entry which trainer will review]

* Learning Objectives:
* Target Date:
* Action plan:
* How will I know when it is achieved?:

[Request generation of second PDP as required]

**Appendix 4 – Trainer prescribing assessment form**

**Trainer prescribing assessment form**

**GP Prescribing Proficiencies**

All prescribing GPs are expected to demonstrate the following, across people of all ages which includes extremes of age, for example babies, children and older people with frailty (based on the GMC GPCs 2017):

1. Assesses the risks and benefits including those posed by other medications and medical conditions, reducing polypharmacy where possible.
2. Identifies when prescribing unlicensed medicines and informs patients appropriately.
3. Adheres to national or local guidelines (including recommendations for over the counter prescribing (OTC) and evidence-based medicine.
4. Uses antimicrobials appropriately.
5. Counsels patients appropriately including giving instructions for taking medicines safety in line with up to date literature.
6. Reviews and monitors effects including blood testing at appropriate intervals.

**Prescribing assessment form**

**From trainee review of 50 prescriptions:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number ofPrescriptions | Prescribing error | Suboptimal prescribing |
| Number scripts reviewed |  |  |  |
| “Right Drug” |  |  |  |
| “Right Dose” |  |  |  |
| “Right Dose Instructions” |  |  |  |
| “Right Follow Up” |  |  |  |
| “Right Documentation” |  |  |  |
| “Right Review” |  |  |  |
| OTC |  |  |  |
| **Total of all errors/suboptimal** |  |  |  |
| **Good Prescribing** |  |  |  |

**1. How accurate was the trainee’s own assessment of prescribing?** *[Randomly sample 20 prescriptions, including those where the trainee has not identified any errors, to make a judgment. If you have good agreement with your trainee’s reflections, then you don't need to review any more. If there is limited agreement, with many errors or suboptimal prescribing being missed or* if *your trainee appears to have assessed most of their prescribing as being either suboptimal or having errors, the assessment criteria and guidance should be discussed and the trainee should re-review their prescribing before you continue the assessment.]*

**2. Comment on your trainee’s performance against the GP prescribing proficiencies in particular which ones were not covered by this assessment? How will these be demonstrated and assessed?**

**3. Has your trainee demonstrated the GP prescribing proficiencies across people at extremes of age, which includes babies, children and older people with frailty? If not, which patients need further evidence and how will this be demonstrated and assessed?**

**4. Please comment on your trainee’s PDP and on any further outstanding learning needs not already covered above? Support them in making their PDP a SMART performance improvement plan to address these if needed.**

**This assessment demonstrates the trainee is currently *[Please highlight one of the following]:***

* A safe, reflective GP prescriber at this point in time ☐

*[It is still expected that they have PDPs to further improve their prescribing]*

* Needs to develop specific prescribing skills to fulfil the prescribing proficiencies☐

*[Those not in the PDP should be reviewed and recorded in a prescribing assessment review]*

* Needs support and educational input prior to repeating all of this assessment☐

***Competencies/ capabilities that may inform, be demonstrated in follow up reviews of the trainees prescribing***

**☐ *Clinical management***-has the trainee prescribed safely, are they aware of and applying local and national guidelines including drug and non-drug therapies, are they aware of legal framework for appropriate prescribing?

**☐ *Community orientation***-has the trainee demonstrated how they have adapted their own clinical practice to take into account the local resources, for example in cost-effective prescribing and following local protocols?

**☐ *Maintaining performance Learning and teaching***-has the trainee shown a commitment to professional development through reflection on performance and the identification of personal learning needs (in their learning log and verbally)?

**☐ *Fitness to practice***- has the trainee reflected on and learnt from (in their learning log and verbally) performance issues (drug errors) in order to improve patient care?

**☐ *Organisation, management and leadership***-has the trainee produced records that are succinct, comprehensive, appropriately coded and understandable?

**☐ *Managing medical complexity***-has the trainee simultaneously managed the patients’ health problems, both acute and chronic (e.g. by taking into account co-morbidities, existing medication and allergies), communicated risk effectively to patients (from documentation in the clinical records), recognised the inevitable conflicts that arise when managing patients with multiple problems and taken steps to adjust care appropriately (taking into account co-morbidities, investigations, existing medication and allergies)?

Appendix 5

**Descriptors of the assessment grades for the prescribing assessment**

**This assessment demonstrates the trainee is currently**

**[Please highlight one of the following]:**

**A safe, reflective GP prescriber at this point in time ☐**

*[It is still expected that they have PDPs to further improve their prescribing]:*

1. Trainee has completed the prescribing assessment as instructed including reviewing 50 prescriptions
2. Trainee has written a reflective log entry on prescribing and uploaded their completed spreadsheet
3. The trainee has not missed any significant errors or many areas of good prescribing in their review
4. The trainee has reflected well on the errors and good prescribing examples they have highlighted in this review
5. The trainee has not made any significant errors or many minor errors that they have not reflected appropriately on
6. The trainee has completed a SMART PDP to further improve their prescribing
7. The trainee has demonstrated many of the prescribing proficiencies in this review
8. The trainee has assessed in this review a range of prescriptions for most common conditions
9. The trainee has assessed in this review a range of prescriptions across people at extremes of age, which includes babies, children and older people with frailty

**Needs to develop specific prescribing skills to fulfil the prescribing proficiencies as identified in the PDP(s) and Q5 above has been fulfilled:**

The trainee has demonstrated 1-6 of the above, however they have:

* Not demonstrated many of the prescribing proficiencies in this review- list those not demonstrated
* Not assessed in this review a range of prescriptions for certain common conditions- list which conditions need to be demonstrated
* Not assessed in this review a range of prescriptions for across people at extremes of age, which includes babies, children and older people with frailty- list which patients need to be demonstrated

**Needs support and educational input prior to repeating all of this assessment:
For example the trainee may:**

1. Not have completed the prescribing assessment as instructed and not reviewed 50 prescriptions
2. Not written a reflective log entry on prescribing or uploaded their completed spreadsheet
3. Have missed significant errors
4. Not have reflected well on errors and good prescribing they have highlighted in this review, showing no suggestions for change or acceptance of the need to improve
5. Have made significant errors or many minor errors that they have not reflected appropriately on
6. Not have completed a SMART PDP to further improve their prescribing

***In addition, the trainee may***:

* Not have demonstrated that they have many of the prescribing proficiencies in this review
* Not assessed in this review many prescriptions for certain common conditions
* Not assessed in this review many prescriptions across people at extremes of age, which includes babies, children and older people with frailty