# Neuropathic AnalGESIC PRESCRIBING Bundle

Practices will randomly sample of 10 patients per Quarter who have been prescribed neuropathic analgesic derived pain relief in the past 3 months, to see if they are reliably receiving the following care:

1. Is there a clear neuropathic pain indication documented and coded?

2. Is there a clear management plan including non pharmacological strategy?

3. Has there been a documented discussion about the risks and benefits and possible dependency if applicable?

4. Is there evidence that neuropathic prescribing has been used in accordance with local pain guidance?

5. Has prescribing been reviewed for compliance, efficacy, tolerability and risk at least annually including an attempt at a graded dose reduction and possible withdrawal to assess ongoing need ?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Key Area** | **Measure** | **To meet criteria** | **Rationale** | |
| Indication and assessment | Is there a clear neuropathic pain indication documented and coded? | Evidence of assessment to confirm neuropathic pain.  Clear indication for the analgesic use should be documented in the patient notes If the patient has had pain for more than 12 weeks the read code 1M52. should be added to their notes if not coded already. | Coding for chronic pain will allow audit and review, and begin the process of implementing and measuring other improvements. |
| Management Plan | Is there a clear management plan including non-pharmacological strategy? | Evidence of clear pharmacological plan and signposting for non-pharmacological strategies/self management approach | SIGN 136 recommends exercise and exercise therapies, regardless of their form and self management for patients with chronic pain. |
| Patient understanding | Has there been a documented discussion about the risks and benefits and possible dependency if applicable? | Evidence of discussion of risks and benefit and risk of possible dependency must be recorded in patient notes | Treatment should only be initiated with caution after a discussion about realistic treatment goals, the potential side effects and longer term risks. Known dependency risk/abuse is higher with gabapentin/pregabalin  N.B. Consideration should be given to starting doses and frequency of increments- e.g. in a patient with history of s/ effects with pain medicines consider 100mg rather than 300mg ( Gabapentin) , 25-50mg rather than 75mg ( pregabalin) or increase dose in weekly increments rather than daily. Dose should be titrated to lowest dose that achieves useful pain reduction or maximum tolerated dose. Continue for 6-8 weeks before assessment. Consider renal function as per product SPC’s when dosing, check annually and adjust dose accordingly |
| Prescription Management | Is there evidence that neuropathic prescribing has been used in accordance with local pain guidance? | Evidence of conforming to local formulary choices | Evidence based cost effective prescribing should be prescribed |
| Review | Has prescribing been reviewed for compliance, efficacy, tolerability and risk at least annually including an attempt at a graded dose reduction and possible withdrawal to assess ongoing need ? | The patient must have been formally reviewed by the GP/pharmacist /nurse or Specialist within the planned timeframe and consultation recorded with clear record of response/benefit to neuropathic analgesic | Follow the Polypharmacy review process as good practice |