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| Corresponding Address |  |
| Tel No. |  |
| Email |  |

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| Title of Audit | Review of Opiate prescribing |

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| Name |  |

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| The feedback that you receive on your audit report can also include the peer reviewer’s comments on whether your audit is judged to be ‘satisfactory’ or ‘unsatisfactory’. Please indicate if you wish to know this judgement. | Yes  No |

Completion of sections 1 – 5 would indicate a ’5 criterion audit’.   
A completed audit cycle would be indicated if sections 1 – 8 had been attempted.

**Standard Audit Report Form**

**Medicine**

Chronic Pain affects 1 in 5 people in Scotland. Analgesic prescribing cost in Scotland accounts for 7% of the Primary Care Drugs Bill and this has doubled between 2003 and 2013. There is strong evidence that patient is at risk of serious harm if they are on regular dose of 80mg Opioid equivelant dose daily. The use of this Safety in Practice Audit tool will help my understand my Opiate prescriptions better.

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| 1. Reason for the Audit |

Explain why the audit topic was chosen and that as a result of this choice there is the potential for change to be introduced which is relevant to the practice or you as an individual practitioner.

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| 2. Audit Criteria to be Measured |

Criteria are simple, logical statements used to describe a definable and measurable an item of health care eg. *Patients with type II diabetes should have a fundoscopy every 12-months*. See Audit Guidance for examples of criteria if greater understanding is required. Focusing on one or two criteria makes data collection more manageable and the introduction of small changes to practice less challenging. Where available, evidence should be cited in support of criteria eg. *nGMS contract or a clinical guideline*. A single criterion is acceptable for Appraisal purposes.

1, Is there a clear indication documented and coded?

2, Is there evidence that the analgesic ladder has been used in accordance with local pain guidance prior to the patient being prescribed a moderate to strong opioid derived analgesic?

3, Is there a clear management plan including non-pharmacological intervention?

4, Is initial prescription an acute and for no more than 30 day supply and are lost or over-ordered prescriptions dealt with in accordance with prescribing policy (if applicable)?

5, Has clinical review occurred effectively prior to the second prescription being issued?

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| 3. Standards Set |

The ideal standard is to achieve 90% of my patient being prescribed a Opioid achieve a 'yes' in the 5 Criteria listed in number 2.

An audit standard describes the level of care to be achieved for any particular criterion eg. *90% of Patients with type II diabetes should have a fundoscopy every 12-months.* Standard levels may be influenced by the target levels contained in the nGMS contract or by discussing and agreeing the desired or ideal level of care with colleagues. State how long you estimate it will take you to reach your chosen standard(s) eg. 3 months.

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| 4. Preparation and Planning |

A Safety in Practice Opioid Bundle tool (adapted from the New Zealand Safety programme) is used for this audit.

Explain briefly who was involved in discussing and planning the audit, how the data were identified, collected, analysed, and disseminated and who gave you assistance at any stage of the project, eg. with a literature review or with collecting or analysing data if this was required. Teamwork is essential to audit and evidence of this should be provided in the report.

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| 5. Data Collection 1 |

With a list from the Practice Pharmacist/Prescribing Support Team, Identify patients who have recieved a prescription for Opioid derived Pain relief (including any medication containing: Tramadol, Morphine, Oxycodone, Fentanyl, Buprenorphine), in the previous 3 months. Ramndomly select a sample of 10 patients to audit. Complete an Audit Data Collection Form for these 10 patients and transfer this to the Spreadsheet and save.

Initial data collected should be presented using simple descriptive statistics as part of the text, in table format or using graphs (bar charts, pie charts etc.) Remember to quote actual numbers (n) as well as the percentage (%). There is no need to quote irrelevant data (eg. age, gender, or past medical history) if it bears no relation to your chosen audit criteria. Compare and contrast your initial data with the standard(s) you set.

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| 6. IMPLEMENTATION OF CHANGE FOR IMPROVEMENT |

The essence of audit is to change practice in order to improve patient care and services. This section should adequately describe any change(s) that was discussed, agreed and introduced by you. The role of others in this process should also be described. An example of the change introduced should be attached in evidence as an appendix to the report, where this is possible eg. a new or amended protocol or flow chart, or a letter that is sent to a group of patients inviting them in for a review.

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| 7. DATA COLLECTION 2 |

Repeat the process in number 7 after every 3 months to see the changes in progress on the Graphs. Repeat the process for a further 2 cycles for the best result of your effort.

Presentation of data should be as Data One. In this section, compare and contrast the results of the second data collection with data collection one *and* the standard(s) you originally set. Has your standard been met or surpassed? If not, comment on why you think that is the case.

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| 8. Conclusions |

The final section should briefly and simply summarise what the audit achieved, and what were the main learning points gained from this exercise. In doing this, the benefits achieved through the audit should be discussed along with any problems encountered with the process or findings. Some thought should also be given as to whether the audit will be repeated in future and if so when.