

Interventions Training

Introduction

During Exeter PCT's monitoring of the new Pharmacy Contract it has become apparent that almost everyone could do with some support in the area of interventions, the why's, what's and how's. This feedback has also emerged from other PCT's visits in other areas.

The aim of this package is to provide an informal training package for both pharmacists and all their staff, in order to clarify the issues, help with the practicalities and overcome barriers to achieving this new way of working.

We will look at:

- Why we 'have' to do them
- Why we should do them
- Working examples for each section to clarify issues such as 'clinical significance' and 'follow up'
- How to get started
- Possible barriers and how to overcome them

In the joined up thinking that we are trying to adopt in Exeter, this package is designed for all staff, because a team approach is needed to support this work. There is a quiz at the end; completed forms can be sent to the PCT for marking and a certificate of completion will be sent to the individual for their training files. There is also an audit attached - more about this later.

I do want to say that this is a personal reflection of the regulations. I am not 'preaching' the only way to do this. The aim of this programme is to guide and support you on your journey. My views may differ from the society's guidance and from other PCT's opinions.

Why do we 'have' to do interventions?

1) The Pharmacy Contract

Let's get the legal bit out of the way!

The service specifications (ie what we're contractually obliged to do) state that for:

Dispensing;
Appropriate advice is given to the patient to:

- Utilise the medicine
- Meet the need for general information about the item
- Advise on safe storage and return
- Where clinically appropriate record the advice, interventions and referrals made

Repeat Dispensing;

Records will be made of any interventions made that are clinically significant in the patient's record.

Public Health;

Pharmacists and their staff give opportunistic advice about healthy living to people with diabetes, those at risk from coronary heart disease (that's basically all of us!) especially people who have high blood pressure, and those who smoke and are overweight. A record of the advice given will be made on the patient's pharmacy record. This record will facilitate service audit and future follow up with the patient. This aspect is specifically mentioned in the monitoring framework for the PCTs.

Signposting;

When the patient is known to the pharmacy, a record of the advice or referral may be made on the patient's record when the pharmacist deems it to be of clinical significance. The monitoring framework also mentions audit of the service and follow-up of the patient.

Support for Self Care;

For patients known to staff, records of advice given, products purchased or referrals made will be made on a patient's pharmacy record when the pharmacist deems it to be of clinical significance.

The monitoring framework again specifically mentions recording in a form that facilitates audit of the service and follow-up with the patient who has been given the advice.

Clinical Governance;

Pharmacists will be encouraged to make records of interventions they have made and advice they have given. The need to make such a record is determined by the pharmacist's professional judgement.

MUR;

A Record of the MUR will be made on the patient's pharmacy record.

2) The Future of Pharmacy

Government policy is to shift all care downwards to make it more accessible to patients, and also cheaper, because we must remember that health funds are limited. Thus GPs are being encouraged to develop services that are now based in hospitals through Practice Based Commissioning.

Pharmacy is an important part of this drive, with enhanced services such as Minor Ailment Schemes and advanced services such as MURs all designed to take pressure off GP services. If pharmacy is seen to be participating, the plan is to eventually develop these services.

Interventions are key to this development also, enabling patients to view pharmacists as an integral part of their health care.

There is also a drive to engage the public in taking responsibility for their own health, and we are obviously ideally placed for this.

However, the danger is that if we do not deliver on this vision, the government will not support the profession, and to put it bluntly, we could all be out of jobs in a few years time, except for a few of us in call centres!

Why should we do interventions?

1) They are good for business.

We pride ourselves on our customer service - why? Because happy customers come back. We have an opportunity to really increase our level of customer service, and get customers for life. Being realistic, which customers do we want - those on long term conditions, especially diabetics and people with blood pressure, because they have lots of lovely scripts that we can collect regularly from the surgery for them and do when we have planned staffing?

2) They are professionally rewarding for all levels of staff.

Isn't it good to 'make a difference'? Interventions allow all levels of staff to get more involved with the patients and feel like they have contributed to improving their lives. I know myself that it is easy to get a bit jaded and feel like you're just churning out scripts like a factory sometimes, but interventions can increase job satisfaction enormously.

3) They 'cover your back'

The society's guidance on interventions tends, I think, to focus on this (surprise!). However, this is important, especially in today's climate of litigation. Having a record of script interventions is just good practice, and has the benefit of increasing safety. Some referrals and advice also come into this category, see the examples below. Across the city we are probably best at recording these type of interventions so far, and it is a good place to start. Refer to the society guidance for more details. I think it is only a minor part of what interventions are all about.

4) They can save time.

Queries can waste an awful lot of time. How many times have you queried a script, sorted it out and sent it back for initialling, only for it to be printed off exactly as before the next time? Even if you remember what you did, or are in that day, what evidence do you have to be sure? The surgery is now closed for the weekend, the patient can't even remember what day it is and now you're stuck.

How many times have you checked an intervention that is a bit weird, only to have to do it next time because you can't remember, either that you've done it, or what the answer was?

5) They enable the continuing care of the patient

You know what you said to them last time. How many times have you been thanked for some advice that you have absolutely no memory of giving? You can follow up advice proactively if you have a record - think of how impressed your patient will be.

6) They increase patient safety

In many cases they are a safety feature and can reduce the risk of future errors.

7) They can increase sales

They allow 'link selling' to other services such as MURs and BP testing/cholesterol testing - or other expensive gadgets like BP monitors, tens machines, (and hopefully in the future, whizzy enhanced services) or to simple things like OTC medicines, books or health supplements.

8) You learn from them

This one's surprising, but you can increase your efficiency, inform your CPD (or training) and boost sales.

9) They save your brain.

We carry far too much stuff in our heads. Who else has problems doing whole sentences after a busy day? By recording interventions where you can get them again, you free your brain for more important stuff, like your life and family.

10) They reduce 'sods law of pharmacy'.

This decrees that the doctor you need to speak to is on holiday, or on a visit, that difficult patients come in on your day off, or at 10 to 6, and that you are sick when your dispenser is on holiday.

Types of Interventions

First let's think about '**clinical significance**' and '**follow up**'.

You could argue that anything that requires the attention of the pharmacist would probably be of clinical significance to the patient. You are probably right, but is that feasible? Not unless we have a psychic link to the computer.

I think that the best ones to record are for the ones that fit into the categories above. Are you likely to want to follow up that piece of information? If not, what is the point of writing it down? What is the point of writing something down that you are never going to look at ever again? Not to please us at the PCT, please.

We have taken the view that it is the quality and follow up of interventions that matter, not necessarily having precisely the correct bits of paper, unless of course they come under the 'cover your back category'. So, if they are on your PMRs, but can't as yet be audited, don't worry.

More of how to record them later, but the following are some examples that illustrate the reasons above and how they fit into the contract. I should stress that most are real and come from a couple of days out at the coalface, or are ones I wish I had made a record of.

Dispensing

Let's start with a classic heart-sink one.

'Interaction- Leflunamide (what?) with methotrexatate - major risk of liver toxicity.'

Gulp. As a locum, I dread these ones. I usually assume that if someone has had medicines before, that the interaction has been checked previously. Not a guarantee, but a realistic decision. With something like the one above, I would want to know that it had been checked.

DRAFT

J Hall Exeter PCT

May 2006

Sod's Law states that the doc wouldn't be there, and there was no note on their medical records. Big hassle! If there was a note at the surgery that it had been queried, how stupid would you look?

Thank goodness for me, someone had already checked, and there was a note on the computer. Phew!

'Query - script nearly illegible - confirmed with repeat (sat) and surgery sending new script - Jen'

This covers your back, explains why a new script turns up, and allows you to chase it when it doesn't (saving time). Adding a name at the end is good to allow follow up with the person who did it - I do this especially as a locum pharmacist.

'Intervention- advised re using beclom regularly as new' (note I go against the society's recommendation not to abbreviate - its up to you!)

Pretty basic, yes, do that anyway, yes, but having it on record allows you to say next time - how are you getting on with it? This at a minimum allows you to reinforce what you said before, but how impressed is that patient going to be that you remembered? It catches any compliance issues in the bud, and if there are problems, you could do an MUR.

'Intervention - warf new- advised re yellow book/tests/taking- suggested coming in for MUR if muddled- Wife looks after meds.'

This covers your back, links to other services and highlights possible family/DDA type problems to watch out for in future. There is also a potential link here to signpost to carers or social services

Repeat Dispensing

'Intervention- not had parac this time- not needed-advised re pain control.'

I have a standard paracetamol spiel (8/day ok - keep pain away rather than letting it get bad etc). It's one of my 'things' so I would know what this means - and would try and follow up.

You could possibly think of some standard interventions you would always make.

'Intervention - had script for 10mg lisinopril- queried with Dr C- gone up from 5mg on repeat disp - marked on scripts'

This is a safety one - just in case it's not clear on the repeat authorisation.

Promotion of Healthy Lifestyles

'Health Promotion- salb new- ask if smoked (valid for asthmatics) light smoker, thinking should quit, signposted to Smoke Cess.'

Do you start to see how the contract fits together? If you've had Brief Intervention Training, you know about assessing where someone is on the cycle of change - this will allow you to gently prod/reassess where they are when you see them again - it may not be the right time for them to listen today. If you run a smoking cessation service you can increase your business too, or possibly they might come back to buy NRT - potentially good for business!

'Health Promotion- Bendro new, advised re salt, given healthy living leaflet.'

There is loads of evidence that healthier living can make as much of a difference as taking tablets - that's a real difference to someone's life. The next time they come in, you can ask them how they are getting on, possibly signposting to Stroll on Exeter, or they may need a MUR.

Signposting

'Signposting - daughter collected rx- mr & mrs not coping so well- referred to social services (should also have done age concern and offered delivery service).daughter lives in b'ham. May need delivery/ DDA/MUR/other help.'

If you now get a panicky phone call, you will know the background to it. It also shows the reflective learning potential of making interventions. I have now thought about that situation and will be better next time. I also realised that the PCT could provide a bit more information on what services might be available. Completing your signposting audit forms will help to identify such areas. It was well worth the effort for the look of relief on the daughter's face, she was really grateful.

'Signposting- mum concerned re daughter- temp and looking a bit floppy. No rash but sent ?'

I made this one up (although it has happened to me) - where would you – GP/D. Docs for urgent referral or straight to A&E? It probably depends where and when you are. Whatever. It is documented if Mum ignores your advice. On visits I have seen anonymous interventions like this recorded on the signposting audit form - seems like a good place. The diary if you keep one, is another, and alternatively you could set up an 'unknown patient' on the computer. (There is no requirement to keep anonymous interventions, but you might want to in some cases.)

Self Care

This is trickier, as it covers advice about long term conditions, and OTC recommendations. Counter staff are absolutely key to progressing this one.

'Referral - ace causing cough? Sold simple linctus till speaks to Dr.'

You can follow up if no change in script. When customer comes back with different meds you will look terribly clever and be able to remind the customer that it was your idea! This is why your OTC protocols are important, and why you need the support of your counter staff to alert you of appropriate interventions.

'Self-care - creams new advised aqueous reg and hydro sparingly.'

This was for a baby - young mums are good and loyal customers, so worth going the extra mile for. We can check up next time, add a bit more advice, or possibly do an MUR- nice easy one that really could make a difference - itching is horrible, and distressing for Mum.

'Self-care - mebev new- advised re taking and diet.'

Again, a simple one that we probably see quite regularly. I have a 'thing' about bowels etc, so I am interested in these patients and find it professionally rewarding to help them and follow them up. It also gives the opportunity for link selling, acidophyllous, or a book, some buscopan if the mebev doesn't work. You probably already stock items that you like to recommend, but recording the interventions helps to focus your mind on what you might need, this might include high profit lines like BP monitors.

'Self care- discussed use of statin- doesn't want to take. Advised re Benecol etc and diet. Suggested chol test' (if you do them, or could refer to local pharmacy that does). You can keep an eye on this patient, and possibly persuade them to try the statin - these make a big reduction in risk, which the patient might not realise, so will make a big difference to their long term health (also an extra item a month).

'Self care- wanted to buy sol. Para. Sold but advised re salt, rep collected, will explain to patient- suggested caplets may be ok.' Soluble tablets contain loads of salt, and this lady had BP. Caplets rather than solubles could make a big difference to her condition, as 4.5 soluble tablets have about the same opposing action to a bendroflumethiazide tablet.

Some self-care referrals are clinically significant and they may never go past the pharmacist. Good counter staff may approach their pharmacist with worries about customers, or worries that someone may not be using a medicine quite correctly, or too often. Recording these incidents as Interventions can help you to keep continuity of care. Here is an example I have been using:

Doris is serving Mrs C, a regular customer who has just had a baby. She has picked up some St John's Wort. Doris checks re interactions, but in the course of the conversation, is a little worried that Mrs C may have postnatal depression. Just by recording the conversation, you are more likely to remember, when she comes back to buy nappy rash cream, to ask how she is feeling. If she comes in for a pill script, you can warn her about the St John's Wort. The opportunity may arise where you can check how she is and refer her to the docs for help.

What about sales of, say Sudafed, to a regular customer? I would say a general sale giving advice about a cold is not worth recording, because you are never likely to use that information again. If they were flying in 2 days time, you sold them some, perhaps after a discussion about thyroid, or diabetes, but also referred to doc, then you might, to cover your back. If they were an occasional add-on to hayfever treatments, you might, so that you could check how often they need them when they come in for their beconase - they might need an MUR!

I have seen some instances of 'cover your back' interventions being recorded anonymously in the diary, and you may want to do this. As I mentioned before, you could set up an 'unknown patient' on the PMR to do this on the computer, then they are all in one place if there is ever any comeback.

The other thing you could do is set up a 'Worried about usage' patient. I tend to handle patients I am concerned about with something like 'we have noticed that you have been in for X recently, what was the problem (depending on whether I have my tactful hat on that day)? Then refer to doc, both to get checked, and save money, perhaps. When they come in next time and haven't been to doc, you have a reasonable reason for not selling to them. This takes teamwork, and the ability to know what was said last time - so a record can help. You could also track usage this way - are you imagining that they are in every 3 days?

Malaria Tablets

Especially these days, a record of which and why you have recommended is useful, just in case.

Examples of other uses

Saving time

'Referral- phoned to ask where Oxygen was- chased with air products (Sue Harvey) she will chase with Dr. Warned surgery she was phoning.'

A classic Friday afternoon one (before a Bank Holiday). I chased air products myself, as the patient wasn't really capable, and ours was the number she was phoning! Sure enough she phoned back on Saturday, and I could reassure her that everything was in hand.

Continuity

'Intervention- needs MUR and DDA- wanting tabs too early on Sat (but couldn't say which ones)-can't see- confused. Ref. to d.docs (Sorry told off)- Jen'

Classic Saturday one this, and a good story - a typical difficult customer - brought repeat in on Fri, came back Sat (on way to pub) to collect. Because the staff have a procedure and stick to it (plug for SOPs) I was able to say really confidently that he would have been told when it was due back (saving trying to find out who had spoken to him). As he didn't know what he wanted, I was unable to help him, referred to D.Docs but he wasn't going to do anything about it!

I was a very bad locum and was a bit stern with him, and told him he must come in for a MUR, as he obviously needs some help. By explaining the situation, the regular pharmacist can apologise for the terrible locum next time he comes in, but still insist he gets some help. By sorting out his problems (repeat dispensing, script collection, big labels, getting quantities sorted) we will save time and hassle in the long run. See how it all starts to fit together?

'Intervention- please query with Dr- seretide acc shouldn't be 2puffs bd-salmel overdose.'

Another classic - surgery closed, but instead of writing on a sticky (which could get lost), it's on the PMR, and you use the label to attach to script (backing attached) safely. If the customer comes before it is queried, you know where to find the script. When you have the answer, it gets recorded, so when they come in next time, and the script hasn't changed, you don't have to repeat the process, but have evidence for your actions.

Learning from Interventions

What I didn't realise, until I started my blitz on interventions, was how much learning you can gain from doing them. I learnt that people running out of their tablets on a Saturday is an issue, and from a PCTs points of view, I am now working out if we can ease the system.

I learnt that doing MURs for some patients could really help with those 'problem' patients that tend to be very time consuming.

I learnt I like talking about pain and bowels, so would probably look out for some useful leaflets, books, or products that will benefit the patient, and my business.

Doing significant event analysis or root cause analysis (this is where you take a close look at what happened to see if there is a way of avoiding it, or doing it better) from your

records of interventions can help you to identify learning and improvement, and potential business opportunities.

How do we get started?

How do you identify who might need an intervention?

It is especially difficult if the pharmacist is not seeing the PMR when labelling. This is where the role of dispensers is key. They may highlight to the pharmacist new items, but that is an interruption that isn't necessary. By jotting on the script, a **N** for new items ↑for increases in dose and ↓for decreases in dose, the pharmacist can identify patients that may need interventions.

It is absolutely **key** to this whole process. I know those of you that have already implemented it have found it really useful. Part of this essential process is also looking for previous interventions. I have suggested that you review your SOPs to include this, (another plug) - using SOPs this way ensures everyone is trained on the new way of doing something, and change is easier ('oh, I forgot' shouldn't then be an issue).

How do we record on the PMR?

The new computer systems that are about to come online will have whizzy intervention packages, I'm sure. Lloyds and Boots's systems already allow you to record 'interventions', but not to audit them. For other systems, there is an option of setting up interventions as 'drugs'. An SOP telling you how to do it for your computer system is available from the PCT.

The advantage of setting it up this way, rather than recording it as a note, is that it is easier to date-link, and audit it. It produces a label, which is quite useful. This can be attached to the bag, if the patient isn't there, and put into a book (either chronologically, or alphabetically). It is quite likely that the new computer systems may lose information from your old one, so keeping them in a book is a good idea for now.

I have suggested setting up several 'headings'. These aren't set in stone, so do what works for you, but they are designed to enable the auditing aspect of the contract more easily. Remember you may have more than one type of intervention for a patient - will separating the categories make it easier, or harder, to see what you've said each time? Play with your dummy patient and see what you think; it may depend on your computer system. On reflection, there are pros and cons of both systems, and I think it is a personal choice. Make sure whatever you choose to do is clear for your locums.

Getting advanced: Follow up!

Using N+1

This allows follow up. I haven't worked out how to reprint a previous intervention without repeating it again on the computer systems I've played with, so please can someone clever have a play and let me know. You could always do another one e.g. ventolin new last time smoke cess advice followed up.

Where Next?

-Our system for doing interventions is set up, but where do we start with the different areas of the contract? Getting started may well be difficult where you have not usually 'got out there' with your patients, for whatever reasons.

Dispensing

Start with new items. Knowing this really helps to identify which patients to talk to, and saves you wasting time talking to people you may not need to. A robust 'see pharmacist' system is necessary for this too. You may just start with things that you are interested in, (for me, as I said, I like bowels and pain). Focus everyone's CPD/training around these areas to start with. There is also a link here to other areas of the contract such as self-care and signposting.

If the patient isn't there, you can do the intervention on the computer beforehand e.g. lisinopril new, advised re hypo. This is an easy one, it covers your back, in case they fall over, starts up a relationship, and patient is impressed that you remember what his tablets are. If you aren't there when he comes back, or you have forgotten what you wanted to speak to him about, it's all there with the script. As a development role for staff, they may be able to help you with some of these.

Move on to increases and decreases in dose. I tend to advise with increases, it's often an opportunity for other aspects of the contract, or a chance to reinforce messages. I tend to assume a lot of decreases are errors by the surgery, and it does help if you can highlight these before the customer leaves the shop. They will come back and say in a loud voice in front of a shop full of customers - 'you have given me the wrong thing!'

Health Promotion

There is an enormous potential here for loads of interventions - where do you start? How do you tell someone they are fat or you can tell they smoke because they stink?

If they have had a change in their medication, it is a good excuse to offer some advice in a non-personal way.

We have had some interesting discussions on how to achieve this in very busy pharmacies, having the right leaflets to hand so you attach them to the bag at the time of checking is one option, 'your X is new (this is how to take it). Changing some lifestyle things can really make a difference- here is a leaflet'.

Again, staff can really get involved with helping to achieve this. If a record is made on the computer you can follow up next time.

Signposting

A new script for BP tabs may mean you signpost to Stepping Out, Smoking Cessation, or a useful website.

Support for Self Care

New codeine with paracetamol may mean you can sell some cod-liver oil or glucosamine (or senna!) I would always give my 'pain control lecture' in this case too.

See what I mean about 'N' being the key?

What are the Barriers? And how to overcome them.

I don't have time

With my harsh hat on, I would say, tough. The contract has been negotiated from on high, and they have to be done. If you really don't have time, you need to speak to your line manager about staffing issues or support.

Now change hats.

It isn't usually about the quantity of staff, it is about how clever you all work. I have realised that pharmacists are control freaks and are generally not great at delegating-myself included, and with good reason.

Being out there with your customers, does put a strain on your support staff, and that is where training and development are so crucial.

The PCT want to support you in this, and help you to enable your staff; the work of the LPC and the Pharmacy Collaborative is also geared around supporting you. Therefore ensuring that all staff do this training package will be worth the investment.

To make it easier, it has been written so that you can just hand it over. It is also the reason that most of you have training and development work in your action plans following the monitoring visits. Empowering staff to do other tasks will free up pharmacists time. Once you start the process, you will often find that staff may come up with their own solutions - as long as the pharmacist is open to suggestions! The time saved on the queries should in some way counteract the increased time making a positive contribution.

Please consider the development of checking technicians wherever possible, those pharmacies that have them have really been able to make a difference in their work patterns.

Computer Access

Some script volumes, work flow, or the systems themselves, don't allow easy access without disrupting the dispensary flow.

Quite often, if you have a query, you will go into the PMR to have a look anyway. You can do a few things while you are there.

Record the intervention there and then - print out a label with what you are going to say, and then attach this securely to the script bag. It acts as a reminder too, or can enable someone else to do it if you aren't there. If you can't print a label, record what you are going to say, print a bag label, and use it a post-it. This can then get stuck straight in your book, if you are keeping one. If you don't know what you are going to say, print a bag label and then jot a note on it afterwards.

Keep a box or clip by the computer, and put them all in one place for adding onto the PMR during quieter times. If it is a script query, scribble a note on it, or a post-it, and put it on the clip/box.

I'm doing this anyway - why write it down?

I hope I've shown you that getting into the habit of recording interventions on PMRs is worthwhile, that they can save time, and that follow-up is worth doing for both business and professional reasons.

Working Patterns

Barriers will be different in different shops the audit will help you to identify these and work to overcome them. I don't have all the answers- sorry!

Resistance to change

Get over it! You are wasting more energy by resisting, and it holds back your staff from helping you, and you have no choice - it's got to be done. I just hope I have convinced you there are sound reasons for doing interventions.

Recording as drugs messes up my script numbers on the computer

Yep it does. I haven't an answer to that, except that the computer numbers aren't very accurate usually, you will have to rely on your paper figures.

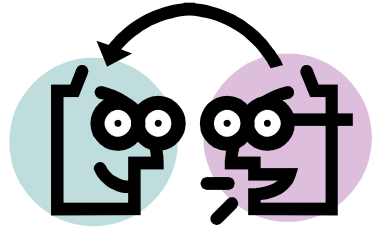
Conclusion

As I mentioned before, being seen to be proactive in making a difference to patients, either through interventions, or MURs, is essential to ensure the future of pharmacy as we know it. I hope this package will enable your staff to understand and support you in this new way of working.

At Exeter PCT, we are trying to encourage 'joined up thinking'. The audit attached should help you make and record your progress. Part of the action stage of the audit is this training. There is an assessment attached. If staff complete this, and send it to me for marking, I will return a certificate of completion for everyone's training file.

I didn't want to overwhelm you with examples, but I have more, if anyone is still struggling, hopefully you have enough ideas to get started.

Interventions- Checking Your Understanding



Name _____

Pharmacy _____

Date _____

Give two reasons why you **have** to do interventions

Give three reasons why it is **good** to do interventions

What are the **four areas** of the contract that require interventions?

Give **two examples** you can think of where an intervention might result in a link sale:

PTO (Faxback to; Jennifer Hall Exeter PCT 01392 494726)

Interventions- Checking your Understanding (Continued)

Name _____

Give two examples you can think of where you might have wanted to follow up a customer:

Give one example you can think of where you might save or have saved time by recording an intervention

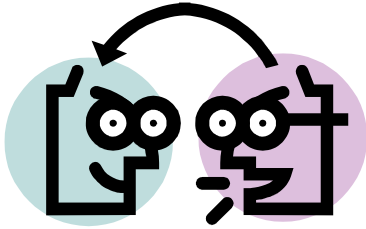
How are you recording interventions in your shop?

How do you know if the pharmacist needs to speak to a patient?

Post Completed forms to:

Jennifer Hall
Exeter PCT
Dean Clarke House
Southernhay East
Exeter EX1 1PQ

Or Faxback to: 01392 494726



Interventions Audit

As audit is another fairly new thing, I will explain each step as I go

Why are we doing this audit?

Audits are designed as a process for checking performance of some sort against a standard, or targets. The point of doing them is sometimes seen as just a checking up on a system, or a proving a point system, but really the point is to look at what you are doing, work out if you can do it better, and to close the loop, actually do something you think will help, and then see if it has made a difference. Thus, good audits should go in a cycle.

As such, it is sometimes a bit of a waste of time doing an audit around something you are pretty sure you are already quite good at. The process may thus start as a quick audit, to see if you need to do a proper audit. Owings are a good example. Most of you already monitor your owings percentage (why? because owings annoy customers). If your percentage falls within company standards (most people work on about 1-2% but this may vary), and your customers seem happy, then you probably don't need to do an audit. If you look at it quickly and find your percentage is quite high, or customers are moaning, or you end up delivering lots of owings, you may want to look at it in more detail.

So, with our quick audit during the monitoring visits, we have established that pretty much all of you are struggling in this area, and it needs improvement.

The first step

The first step in any audit is to find out what you are doing at the moment. The initial audit (see later) will establish this.

Identify a standard

This is what you are aiming for. It may be an established standard, for example with owings, you may have a company standard of 1.5% which you are judged on. If it is a clinical audit, the standards are usually evidence-based, for example from NICE guidance. You may decide your own standard, based on the needs of your business.

As far as interventions go, the monitoring framework suggests that the PCT may view a 'sample' of 20 interventions for each category. This suggests that there should be more than that. No one at the moment has anything like that rate.

When we visit again (around Sept/Oct time) to check your progress against your action plans, we would expect to see the rate of at least 20 for each category (dispensing, health promotion, signposting, self-care). That's 80 per year, about 7 per month. That is the minimum figure, but a good place to start. You may choose to set your standard higher. As another guide, I did 22 in two days recently, but that required a BIG effort for me and the staff, and I won't pretend that level is easy, although I did really feel like I

had made a difference over those couple of days. It will gradually become a habit that you just do.

Action

Work out what you are going to change, or how you might do things differently.

I have given an example using significant event/root cause analysis, over a period of time, to show you how you can use this as a tool for working out improvement. This needs to involve all your staff.

The action part of the audit details what you are going to do.

See what happens.

That is, re-audit. It is best to ask the same questions you did originally to get a true picture of what has happened. As we are setting up systems that can be easily audited, monitoring your rate of interventions should be quite easy. If it isn't, please can I stress that doing them in a way that allows follow up is far more important to us as a PCT than having the right bits of paper to show us. If all you can do is a page of bag labels, that's fine.

Take more action.

You may have done some things, and seen an improvement, but not as much as you'd like, go back to a significant event analysis-type process, and try and work out what is stopping you. Make changes

See what happens again.

You can go round the cycle as many times as you need to, in order to get the improvement you need.

I am suggesting we do this once a month, over at least a three month period.

Sharing

It would be really useful to be able to collate and share the results of this audit. Results would be anonymous, and no one will be round with a big stick if you aren't doing very well.

The audit will also be evidence of a practice based audit for the contract monitoring next year, so keep a copy safe.

Please fax-back results of the training and audit to: Jennifer Hall, 01392 494726

Or post to: Jennifer Hall
Exeter PCT
Dean Clarke House
Southernhay East
Exeter EX1 1PQ

Interventions Audit

Initial Audit – for **April 2006**

Name of Pharmacy _____

Remember this is an honest appraisal of what you were actually doing! (i.e it doesn't matter if it was bad- that's how you learn)

Figures

Last Month (April 2006) we did _____ interventions

Of these: Couldn't find evidence of numbers _____

Number on PMRs _____

Number Recorded on Paper _____

This is _____% of total scripts

Staff Training

No. of Pharmacists _____ No. completed training _____

No. of Dispensers _____ No. completed training _____

No. of Counter Staff _____ No. completed training _____

We have set up some kind of computer system to record interventions Yes/No

We have set up the PCT System Yes/No

We have our own system set up Yes/No

Systems

We use N ↓↑ to highlight changes to PMR (tick): None of the time
Sometimes
Nearly all the time
Absolutely every time

We have a clear system for 'see pharmacist' Yes/No

Our system for 'see the pharmacist' is: _____

Our SOPs include:

Recording Interventions,
On the computer Yes/No

On paper Yes/No

Target Number of Interventions _____ or target% of scripts _____

We are making the following changes _____

Fax-back to Jennifer Hall, Exeter PCT on 01392 494726

Interventions Audit

Re- Audit –Month: _____ Name of Pharmacy _____
(suggest monthly for 3 months)

Figures

Last Month we did _____ interventions

Of these:

Number on PMRs _____

Number Recorded on Paper _____

This is _____% of total scripts

Staff Training

No. of Pharmacists _____ No. Completed Training _____

No. of Technicians _____ No. completed training _____

No. of Counter Staff _____ No. completed training _____

We have set up some kind of computer system to record interventions Yes/No

We have set up the PCT System Yes/No

We have our own system set up Yes/No

Systems

We use N ↓↑ to highlight changes to PMR (tick): None of the time
Sometimes
Nearly all the time
Absolutely every time

We have a clear system for 'see pharmacist Yes/No

Our system for 'see the pharmacist' is _____

Our SOPs include:

Recording Interventions,

On the computer Yes/No

On paper Yes/No

Target Number of Interventions _____ or target % of scripts _____

We have reviewed our progress Yes/No

We are making the following changes

Faxback to Jennifer Hall Exeter PCT 01392 494726

Significant Event Analysis- Month One- Example

Date

Description of Event- <i>Jenn has said we are rubbish at interventions- we need to show improvement</i>		
	Notes	Possible Actions
What impact did the event have?	<i>We are in danger of not fulfilling our contract requirements</i>	<i>We need to take the actions suggested by the PCT to improve.</i>
What went well?	<i>We talk to our customers a lot- but just don't record it- what's the point?</i>	<i>Systems/ Training pack</i>
What didn't go so well?	<i>We aren't recording very many at all</i>	
Identification of contributing factors/ barriers and problems (root cause analysis with 5 why technique)	<i>We don't understand what its all about really Our recording form takes too much time Don't have time to talk to patients much (You may have a long list, but don't necessarily try to do everything all at once)</i>	<i>All staff to complete training pack and send off answers Add system to computer Look at time saving ideas like 'N' or see pharmacist to identify patients at most need</i>
Actions decided on	<i>All staff to do training Set up computer/ keep labels in A-Z book Use N and ↑↓ to identify patients</i>	

Significant Event Analysis- Month Two- Example

Date

Description of Event: <i>Interventions improved (10 per month) but we want to achieve at least 2 a day</i>		
	Notes	Possible Actions
What impact did the event have?	<i>Starting to see how they can be useful, but not getting enough recorded.</i>	<i>Need to look at why they aren't getting recorded</i>
What went well?	<i>Script interventions going well, but others not very good. Customers like being spoken too.</i>	<i>Need to look at what is stopping us</i>
What didn't go so well?	<i>Self care and health promotion difficult to approach We aren't getting the rate we want</i>	<i>Select a specific group of patients and work out how to approach them in advance- work together as CPD, perhaps try and find a good article for all to read. Analyse more closely</i>
Identification of contributing factors/ barriers and problems (root cause analysis with 5 why technique)	<i>Locums letting us down Can't get to the computer when its busy Self care hard Part-time staff forgetting</i>	<i>Ask them to do training pack Set up clip by computer See above- train Doris on how to add to computer herself. Review and retrain on SOPs</i>
Actions decided on	<i>Going to concentrate on stop smoking for asthmatics and exercise advice for diabetics and BP- found good leaflets. Will try follow these patients up. Clip good idea- will try Doris computer-phobe, can do bag label and will write on them SOPs can't be changed (head office) but are going to show each locum personally and get them to sign a sheet.</i>	

Significant Event Analysis

Date

Description of Event		
	Notes	Possible Actions
What impact did the event have?		
What went well?		
What didn't go so well?		
Identification of contributing factors/ barriers and problems (root cause analysis with 5 why technique)		
Actions decided on		