



National Prescribing Service Limited

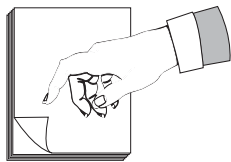
Optimising the use of OTC analgesics

Why an audit on optimising the use of OTC analgesics?

Improving the use of over-the-counter (OTC) analgesics contributes to the overall management of pain. Pharmacists and pharmacy staff play an important role in advising patients on the appropriate choice and use of analgesics.

Please tear off each section carefully.

Submission cover sheet and completed audit forms should be received at NPS by **Friday, 1 December 2006.**



Participation in this audit provides you with an opportunity to:

- optimise the safe and effective use of OTC analgesics by recommending a stepwise approach to self management of pain
- identify patients who have a contraindication to, or the potential for drug interactions with, an analgesic
- ensure internal systems for referral are functioning appropriately
- demonstrate provision of quality care
- assist with staff education.

How to participate

1. Select patients

Select a minimum of 10 customers (aged 13 years or over) who present to the pharmacy with a:

- direct request for an analgesic product
- symptom-based request for which you consider an analgesic product to be appropriate.

Patient privacy

Patients must be informed that their health information may be used for quality assurance activities. Please:

- display in your pharmacy the enclosed poster *Quality assurance activities in this pharmacy and your privacy*
- ask patients/customers to read the poster.

2. Collect data and review

- Complete one double-sided audit form as soon as possible after your interaction with each of your selected customers.
- Check this *Guide* for supporting information to help you complete your audit forms.
- Complete the *OTC review and action plan* and keep for future reference.

Note: Professional Practice Standards stipulate that all consumers be offered counselling on medicines by a pharmacist.¹ The pharmacist should ensure that the consumer has sufficient knowledge of their medicines to facilitate their safe and effective use.¹ Audit forms should be completed by a pharmacist, pre-registration pharmacist or pharmacy assistant under the direct supervision of a pharmacist.

3. Return the audit forms

Return a minimum of 10 audit forms and the *Submission cover sheet* to:

**NPS Pharmacy practice audit
Locked Bag 4888
STRAWBERRY HILLS NSW 2012**

To be received at NPS not later than:

Friday, 1 December 2006

Please note: Late submissions cannot be accepted.

4. Professional development

This audit is recognised by the:

- Pharmaceutical Society of Australia (PSA) Continuing Professional Development and Practice Improvement (CPD & PI) Program. Registered pharmacists who are PSA members are eligible for 8 CPD & PI points (or State equivalent) according to PSA Guidelines
- Australian Association of Consultant Pharmacy (AACP) for 8 credit points
- Pharmacy Guild of Australia (PGA) Quality Care Pharmacy Program/Continuous Quality Improvement (QCPP/CQI) for 1 point (under 1st edition)
- Society of Hospital Pharmacist Association (SHPA) Personal Continuing Professional Development record for 4 hours.

At least 10 completed audit forms must be returned if you wish to obtain professional development points or recognition of this activity from any of these organisations.

Notes for the audit form

The following guidelines were used as the basis for this Pharmacy practice audit:

Therapeutic Guidelines: Analgesics, Version 4, 2002.

Australian Medicines Handbook, 2006.

Low back pain: rational use of opioids in chronic or recurrent non-malignant pain. Prescribing guidelines for primary care clinicians. NSW Therapeutic Advisory Group, 2002.

Advice from the CSM expert working group on analgesic options in the treatment of mild to moderate pain. British Pain Society/Medicines and Healthcare products Regulatory Agency, 2006.

Completing Section A: Screening the request to determine appropriateness of analgesic use

Establish who is making the request and if it is for a specific product or symptoms. Determine if referral to the pharmacist is appropriate and gather further information to assist the appropriate choice of product.

Requested analgesia — Assess if the patient has previously used the analgesic for the current problem. Determine if symptoms were controlled and if dosing was appropriate.

Use of other medicines — This may influence the choice of analgesic recommended. See Table 1 (page 5) for medicines that may potentially interact with NSAIDs; use NSAIDs with caution.

How long have the symptoms been present?

Consider referring to a GP, patients with:

- pain unusual for that patient
- pain with no obvious cause
- non-resolving symptoms when using an analgesic at an adequate dose and duration for the current problem.^{4,5}

Medication-overuse headache should be suspected when:

- combination analgesics or acute migraine drugs are used on 10 or more days per month.
- simple analgesics are used on 15 or more days per month.⁶

See *NPS News 38 Headache and Migraine*, January 2005 (www.nps.org.au/healthpro).

Relevant health conditions — Assess whether the patient is at high risk of adverse effects with NSAIDs — conventional or COX-2 selective (see Table 2, page 5). NSAIDs may increase the risk of thrombotic events, e.g. myocardial infarction and stroke³, especially in people with a high cardiovascular risk, e.g.:

- established cardiovascular disease
- diabetes and renal impairment
- familial hypercholesterolaemia
- diagnosed left ventricular hypertrophy.

Exercise the greatest caution when recommending NSAIDs to patients at high risk because they will have the largest absolute increase in potential risk of myocardial infarction or stroke when using an NSAID. See *NPS RADAR: Elevated cardiovascular risk with NSAIDs*, August 2005 (www.npsradar.org.au).

Conventional and COX-2 selective NSAIDs have a similar potential to cause hypertension, congestive heart failure and acute renal impairment and can cause serious gastrointestinal events (ulceration, bleeding, perforation).^{2,3} This potential should be minimised by:

- using regular paracetamol first, when appropriate
- avoiding their use in people aged > 65 years and/or with concurrent medical conditions (Table 2)
- avoiding concurrent use of other drugs with a high risk of adverse gastrointestinal events (Table 1)
- using the lowest effective dose for the shortest period of time
- recommending a drug with a lower risk of serious gastrointestinal events. Ibuprofen and diclofenac have the lowest risk of gastrointestinal adverse effects (Table 3, page 5)
- educating patients about symptoms of gastrointestinal toxicity and the action to take.^{2,3}

Paracetamol may increase the rate of progression of chronic renal failure. However, in patients with renal impairment, short-term use of paracetamol is safer than NSAIDs.³ Patients with chronic liver disease may be at increased risk of liver damage after therapeutic doses or overdose of paracetamol, although evidence is lacking.³

Completing Section B: Assess the presenting problem and symptoms

What is the presenting problem?

Clarify the presenting problem to ascertain the most appropriate treatment.

Paracetamol — Recommended as first line for fever and mild-to-moderate pain^{2,3} as it:

- is effective when taken regularly in appropriate doses (insufficient dosing regimens can lead to perceptions of ineffectiveness). Clarify appropriate dosage of paracetamol with the patient:

Immediate-release tablets/capsules

1–2 × 500 mg every 4–6 hours

Maximum 8 tablets (4 g) per day

Modified-release tablets

2 × 665 mg tablets every 6–8 hours

Maximum 6 tablets (3990 mg) per day

Three times daily dosing is useful when

4 times daily dosing is a barrier to use

- has an excellent safety profile (adverse effects or toxicity with paracetamol are rare at therapeutic doses)
- may be used in all age groups
- has fewer adverse effects than NSAIDs.

Simple analgesia and/or non-drug measures should be used first line in headache, back or hip pain, osteoarthritis, strains and sprains, tendonitis, tennis elbow and sinus pain.^{2,3}

NSAIDs* — OTC NSAIDs are indicated primarily for acute symptom relief, not chronic therapy. NSAIDs offer an advantage in dysmenorrhoea, acute gout, metastatic bone pain and inflammatory arthropathies such as rheumatoid arthritis.²

* Not all NSAIDs are approved for use in all of these indications. Check product information for approved indications.

Combination analgesics (fixed dose) – Are they an appropriate choice?

Weak opioids — The lowest effective dose of codeine (the most frequently used weak opioid) is not established but it is generally accepted that doses below 30 mg are unlikely to be effective. A dose of 30 mg codeine plus 1g paracetamol would be achieved by using 2 × Panadeine-15 caplets (S3).

About 10% of Caucasian people and 1–2% of Asian people are poor metabolisers of codeine. In these patients codeine is an ineffective analgesic but may still cause adverse effects.²

Antihistamines — Avoid analgesic products containing sedating antihistamines, e.g. doxylamine (Codalgin Plus, Dolased, Fiorinal/Dental, Mersyndol, Panalgesic); they may have some added hypnotic effect but no additional analgesic effect.²

Topical NSAIDs — These are more effective than placebo when used for a 2-week period for osteoarthritis.¹⁰ Efficacy in musculoskeletal disorders for more than 2 weeks has not been established.¹¹ Their use may be sufficient if symptoms are mild; however, efficacy versus paracetamol in the treatment of local musculoskeletal disorders has not been established.²

Some topical NSAID preparations deliver analgesic anti-inflammatory drug to underlying tissues and, to a small degree, systemically.²

Stepwise approach to mild-to-moderate pain management^{4,12}

Step 1. Paracetamol

Step 2. Substitute paracetamol with an NSAID

Step 3. Add paracetamol to NSAID

Step 4. Continue paracetamol and alternative NSAID

If NSAIDs are contraindicated or not recommended substitute a low-dose opioid in place of or, in addition to, full-dose paracetamol.

Use of paracetamol with an NSAID may allow for a lower dose of NSAID to be used, which may reduce the incidence of NSAID adverse effects.²

Strategies for management of persistent non-malignant pain

If medical advice has not previously been sought for persistent pain refer the patient to their GP for overall review of pain management.⁴

- Use a stepwise approach
- Use regular dosing rather than 'as required/PRN'
- Use maximal doses before moving to the next step
- Assess response to medication after 2–3 weeks
- If no response, review and explore reasons for non-response.⁴

Completing Section C: Assess other medication use for potential drug interactions

Potential for drug interactions with NSAIDs

Assess potential drug interactions with conventional or COX-2 selective NSAIDs (see Table 1).

Consider the implications of the interaction and refer to the GP if appropriate.

Completing Section D: Assess current analgesic use to ensure appropriate supply of analgesic

Use of other analgesics

Determine if other analgesics are being used for the current problem or coexisting conditions, either regularly or as needed (PRN), including prescribed analgesics and OTC products, e.g. cough/cold/sinus preparations containing paracetamol, aspirin or an NSAID. When other products containing paracetamol are being used, confirm the current dose. If a paracetamol-containing product is recommended ensure the patient is aware of the maximum total daily dose of paracetamol to be used.

Product(s) requested/supplied

Specify if the product requested and the product supplied are recommended by *Guidelines*. If the product supplied was not recommended (see Section B), specify your reason(s) for choosing an alternative agent.

Patient advice

- *overall pain management* — did you recommend non-drug therapies such as RICE (rest, ice, compression, elevation) or provide any other information?
- *optimum dosage of drug therapy* — did you confirm the dosage of the drug used?
- *maximum daily dose of analgesia* — did you confirm maximum daily doses of paracetamol containing products?
- *drug interactions* — did you determine if potentially interacting drugs were being used? e.g. for NSAIDs
- *need for antihistamine-containing preparation* — is a hypnotic effect clinically appropriate?
- *bowel health* — did you recommend regular laxatives for patients using opioids? Constipation occurs with chronic use of opioids; tolerance develops slowly, if at all. OTC preparations contain lower doses of opioids

but have the potential to cause constipation. Maintain fluid, diet and mobility² and recommend a regular stimulant laxative or an osmotic laxative to prevent faecal impaction if this is considered necessary.³

- *optimal patient compliance with supplied drug therapy* — did you advise the customer about correct use, frequency and dosing, and about symptoms of serious adverse effects from the medicine, (e.g. dark stools, swollen ankles, heartburn, worsening asthma with NSAIDs)? Note: taking NSAIDs with food or a full glass of water does not prevent gastrointestinal ulceration but may reduce dyspepsia.
- *written supporting materials* — did you provide appropriate written information?
 - consumer medicine information (CMI) leaflets
 - *Pharmacy Self Care Fact Card*
 - General information about medicines: *NPS Medimate*, a consumer-friendly guide to using 'medicines without the mix-ups', available free online at www.medimate.org.au
 - Other useful information resources:
 - www.tga.gov.au
 - www.arthritisaustralia.com.au
 - www.health.nsw.gov.au
 - www.britishpainsociety.org
 - www.nhmrc.gov.au
 - www.oopathway.org.au
 - www.ciap.health.nsw.gov.au/nswtag
- *referral to GP for further management* — did you ascertain if a referral to a GP was indicated? Provide a written advice/referral note if required. Consider referral for:
 - severe or prolonged pain
 - pain in pregnant women
 - patients with concurrent therapies or illnesses as outlined in Tables 1 and 2.

Completing Section E: Self assessment

Identify which staff members were involved with the customer.

Assess your interaction with this customer and identify the main barrier(s) to providing optimal quality advice.

Complete the *OTC review and action plan* to outline your proposed changes to practice, training needs, etc.

Table 1. Potential drug interactions with conventional or COX-2 selective NSAIDs ^{2,3}	
Drug	Interaction
ACE inhibitors and angiotensin II-receptor antagonists	↓ antihypertensive effect — monitor BP and weight ↑ risk of renal impairment and hyperkalaemia
Diuretics	↓ diuretic effect — monitor BP and weight, ↓ renal function
Potassium-sparing diuretics, potassium supplements	may ↑ serum potassium and ↓ renal function, especially in elderly or in renal impairment
Beta blockers	↓ antihypertensive effect — monitor BP
Aspirin (high dose) and conventional and COX-2 selective NSAIDs	↑ risk of gastric ulceration
Warfarin	↑ risk of bleeding — monitor for bruising and gastrointestinal bleeding
Corticosteroids	↑ risk of gastric ulceration
Methotrexate	↑ risk of methotrexate toxicity due to decreased clearance
Lithium	↑ risk of lithium toxicity due to decreased clearance
Cyclosporin, tacrolimus	↑ risk of nephrotoxicity in reduced renal function
Alendronate	↑ risk of gastric ulceration

Table 2. Patients at high risk of adverse effects with conventional or COX-2 selective NSAIDs ^{2,3}	
Risk factor	Adverse effect
Adults 65 years and over	Increased risk of heart failure, gastrointestinal ulceration and renal impairment
Previous peptic ulcer disease	Increased risk of gastrointestinal ulceration
History of renal impairment	Increased risk of conventional and COX-2 selective NSAID-induced renal impairment
History of hepatic impairment	Increased risk of bleeding
Cardiovascular disease	Increased risk of thrombotic events, e.g. MI and stroke
Cardiac failure	Fluid retention may result from reduced renal function induced by conventional and COX-2 selective NSAIDs
Hypertension	Blood pressure control may deteriorate
Asthma	Risk of bronchospasm may be increased
Pregnancy	Category C — avoid use, especially in third trimester

Table 3. Relative risk of serious gastrointestinal events ^{*2,7-9}	
Lower risk	diclofenac, ibuprofen; celecoxib, lumiracoxib
Medium risk	diflunisal, indomethacin, naproxen, sulindac
Higher risk	ketoprofen, piroxicam

* Meloxicam is not included, as there are no comparable gastrointestinal safety clinical outcome trials

References

1. Pharmaceutical Society of Australia. Australian pharmaceutical formulary and handbook. 20th edn. Canberra: The Pharmaceutical Society of Australia, 2006.
2. Therapeutic Guidelines: Analgesics. Version 4. 2002.
3. Australian Medicines Handbook, 2006.
4. NSW Therapeutic Advisory Group (TAG). Low back pain: rational use of opioids in chronic or recurrent non-malignant pain. Prescribing guidelines for primary care clinicians. Darlinghurst: NSW TAG, 2002. <http://www.ciap.health.nsw.gov.au/nswtag/publications/guidelines/LowBackPain41202.pdf> (accessed 17 July 2006).
5. Pharmaceutical Society of Australia. Counselling guide for non-prescription medicines. 4th edn. 2005.
6. Headache Classification Subcommittee of the International Headache Society. The international classification of headache disorders: 2nd edn. Cephalalgia 2004;24 Suppl. 1:9–160.
7. Henry D, Lim LL-Y, Garcia Rodriguez LA, et al. Variability in risk of gastrointestinal complications with individual non-steroidal anti-inflammatory drugs: results of a collaborative meta-analysis. BMJ 1996;312:1563–6.
8. Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis. The CLASS study: a randomized trial. JAMA 2000;284:1247–55.
9. Farkouh ME, Kirshner H, Harrington RA, et al. Comparison of lumiracoxib with naproxen and ibuprofen in the Therapeutic Arthritis Research and Gastrointestinal Event Trial (TARGET), cardiovascular outcomes; randomised controlled trial. Lancet 2004;364:675–84.
10. Lin J, Zhang W, Jones A, Doherty M. Efficacy of topical non-steroidal anti-inflammatory drugs in the treatment of osteoarthritis: meta-analysis of randomised controlled trials. BMJ 2004;329:324–30.
11. Mason L, Moore RA, Edwards JE, et al. Topical NSAIDs for chronic musculoskeletal pain: systematic review and meta-analysis. BMC Musculoskelet Disord 2004;5:28.
12. British Pain Society/Medicines and Healthcare products Regulatory Agency (MHRA). Advice from the CSM expert working group on analgesic options in the treatment of mild to moderate pain. London: MHRA, 2006. http://www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dID=18716&noSaveAs=1&Rendition=WEB (accessed 1 August 2006).

Confidentiality

Receiving your results

When the results have been analysed (around 4 months after completion of the audit), you will receive:

- your original audit forms
- your own results
- the aggregate results of all participants
- expert commentary on the aggregate results
- review and reflection points
- a certificate of completion
- CPD & PI points.

Confidentiality and privacy

You must sign and date the *Submission cover sheet* to participate in this audit.

What will happen to your patient data

- Your de-identified patient data forms are scanned and returned to you.
- Your individual results are kept confidential and are provided to you only.

- Your data are aggregated with those of other participants and the aggregate results (which do not identify any individual patient or pharmacist):
 - are provided to all participants
 - may be used in NPS evaluation and reports.

At the close of the audit cycle (i.e. after individual results are returned to participants), all potentially identifying data (e.g. age, postcode) are removed from NPS records. Your individual audit results will then no longer be available.

What will happen to your personal details

For members, your personal details are provided to the Pharmaceutical Society of Australia for CPD & PI points (or State equivalent).

Your personal details are provided to a mail house for processing and recorded for NPS evaluation.

You can obtain a record of your personal details from NPS by request in writing.

Please note: You are responsible for advising NPS of any changes of address during the audit cycle.

Further information

For more information about the use of analgesics see:

NPS News 47 (visit www.nps.org.au/healthpro)

Prescribing Practice Review 35

(visit www.nps.org.au/healthpro)

Australian Medicines Handbook 2006

Therapeutic Guidelines: Analgesics, Version 4, 2002.

Contact Sheena O’Riordan or Clare Bottomley

Phone: (02) 8217 8700

Fax: (02) 9211 7579

The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence. Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.




National Prescribing Service Limited

Pharmacy practice audit: Optimising the use of OTC analgesics

Completing the audit cycle — OTC review and action plan


After completing the audit forms, complete this review and action plan and keep for future reference.

The process of screening and referral of consumers uses the *Pharmaceutical Society of Australia (PSA) Standards for the Provision of Pharmacy Medicines and Pharmacist Only Medicines in Community Pharmacy* (revised November 2005).

	OTC review			OTC action plan		
	Assess current practice in your pharmacy			My action plan	How I will implement this plan	Due date
	Yes	Usually	No			
Resources (PSA standard 1)	If you tick (✓) a shaded box below, complete the OTC action plan 					
Were consumers able to access the pharmacist for consultation on OTC analgesics?						
Did staff have timely access to the resources needed to provide service and information to the consumer? e.g. <i>Australian Medicines Handbook, AusDI, Therapeutic Guidelines.</i>						
Did the consumer have access to current information materials? e.g. CMI, <i>PSA Pharmacy Self Care Fact Cards, NPS Medimate, NPS Medicines Line</i> information.						
Staff training (PSA standard 2)						
Did consumers purchasing analgesics have appropriately trained staff assisting them with their product selection? Consider communication skills training, role play situations that staff find uncomfortable (e.g. requests for combination analgesics containing antihistamine with no therapeutic indication for antihistamine).						
Have you identified gaps in your or your staffs' therapeutic knowledge around analgesics? e.g. dosing of paracetamol modified-release products, appropriate use of combination analgesics, medication-overuse headache.						

Pharmacy practice audit: Optimising the use of OTC analgesics

Completing the audit cycle — OTC review and action plan (CONT'D)

	OTC review Assess current practice in your pharmacy			OTC action plan		
	Yes	Usually	No	My action plan	How I will implement this plan	Due date
Consumer care and advice (PSA standard 4)	If you tick (✓) a shaded box below, complete the OTC action plan 					
Does the pharmacy have a functioning procedure for 'Responding to Consumer Requests'?						
Have all staff recently completed training in using the procedure 'Responding to Consumer Requests'?						
Did pharmacy staff respond appropriately to consumer requests for analgesics?						
Did pharmacy staff refer consumers to the pharmacist appropriately?						
Were consumers appropriately referred by the pharmacist? (e.g. to general practitioner, support services)						

Other issues

Other issues surrounding the supply of OTC medicines but not covered explicitly in this audit include indirect supply, documentation, display and storage, consumer consultation, and the rights and needs of consumers. These issues should also be considered in your review and action plan.

Pharmacy practice audit: Optimising the use of OTC analgesics

Completing the form

The pharmacist, pre-registration pharmacist or pharmacy assistant may complete these forms. Pharmacists may wish to oversee completion of all forms to assist with staff training.

Forms should be completed as soon as possible after serving each adult customer who:

- directly requests an analgesic product, or
- presents with a symptom-based request for which you consider an analgesic appropriate.

- Use a black biro to make a cross (X) in the box for your response.
- If you make a mistake, use white correction fluid.



NPS office use only

Section A: Screen the request to determine appropriateness of analgesic use

1. Is the customer the patient?

- yes no not asked

2. Patient age:

- 13–65 years > 65 years not asked

3. Customer presentation:

- Direct product request ▼ Symptom-based request

Specify _____

Did a doctor recommend the analgesic requested?

- yes no not asked

4. Has the patient already used the requested analgesic or any analgesic for the current problem?

- yes ▼ no not asked

Were symptoms controlled?

- yes partially no not asked

Was dosing appropriate?

- yes no not asked

5. How long have the symptoms been present?

- not asked < 2 weeks 2–12 weeks > 12 weeks
- Chronic condition: consider referral to GP

6. Is the patient currently taking any other medications?

- yes no not asked

7. Does the patient have any other health conditions?

- yes ▼ no not asked

Consider referral to GP for any of these conditions

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> breastfeeding | <input type="checkbox"/> asthma | <input type="checkbox"/> kidney disease | Caution when using NSAIDs, especially in elderly |
| <input type="checkbox"/> pregnant | <input type="checkbox"/> diabetes | <input type="checkbox"/> liver disease | |
| | <input type="checkbox"/> heart disease | <input type="checkbox"/> peptic ulcer | |

NOTE: If ONE OR MORE highlighted responses were marked by a pharmacy assistant, the customer should have been referred to the pharmacist.

Section B: Assess the presenting problem and symptoms

8a) What is the presenting problem?

- | | |
|---|--|
| <input type="checkbox"/> backache or hip pain | ▶ paracetamol preferred or conventional NSAID |
| <input type="checkbox"/> headache | ▶ paracetamol or aspirin |
| <input type="checkbox"/> strains and sprains | ▶ RICE ± paracetamol |
| <input type="checkbox"/> osteoarthritis | ▶ paracetamol |
| <input type="checkbox"/> sinus pain | ▶ paracetamol ± codeine |
| <input type="checkbox"/> fever | ▶ paracetamol |
| <input type="checkbox"/> tendonitis, tennis elbow | ▶ paracetamol — topical NSAIDs or rubefacients can be considered |
| <input type="checkbox"/> migraine | ▶ soluble aspirin, soluble paracetamol or conventional NSAID |
| <input type="checkbox"/> dysmenorrhoea | ▶ conventional NSAID (other than aspirin) |
| <input type="checkbox"/> other _____ | |
| <input type="checkbox"/> not asked | |

Guideline recommendations: first-line choice

b) Has the patient previously used paracetamol for this problem?

- yes no (Consider paracetamol) ▶ Go to Q9
 not asked ▶ Go to Q9

c) Were symptoms controlled?

- yes (Paracetamol use recommended) no ▼ not asked

Was dosing appropriate?

- yes (Refer to Guidelines for alternative, see Q8a)
 no (Consider paracetamol at optimum dose)
 not asked

Section C: Assess other medication use for potential drug interactions

9. If considering an NSAID, indicate if any of the following drugs that may interact were being used:

- | | | |
|---|--|--|
| <input type="checkbox"/> not applicable | <input type="checkbox"/> anticoagulants | <input type="checkbox"/> lithium |
| <input type="checkbox"/> not asked | <input type="checkbox"/> aspirin (high dose) | <input type="checkbox"/> methotrexate |
| <input type="checkbox"/> none | <input type="checkbox"/> beta blockers | <input type="checkbox"/> potassium supplements |
| <input type="checkbox"/> ACE inhibitor | <input type="checkbox"/> corticosteroids | <input type="checkbox"/> tacrolimus |
| <input type="checkbox"/> alendronate | <input type="checkbox"/> cyclosporin | Consider implications of interaction, refer to GP if appropriate |
| <input type="checkbox"/> angiotensin II-receptor antagonist | <input type="checkbox"/> diuretics | |

Section D: Assess current analgesic use to ensure appropriate supply of analgesic (mark all that apply)

Complete Q10–12 ▶	10. Requested analgesic:	11. Other analgesics used for current or coexisting problems (prescribed/OTC):	12. Supplied analgesic:
Drug			
none	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol 500 mg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol 665 mg modified release	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol + codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol + codeine + antihistamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol + metoclopramide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paracetamol-containing cough/cold/sinus preparation		<input type="checkbox"/>	
paracetamol + dextropropoxyphene		<input type="checkbox"/>	
↓	TOTAL daily dose of paracetamol used:		
	<input type="checkbox"/> < maximum <input type="checkbox"/> maximum [standard release 4 g/day modified release 3.99 g/day <input type="checkbox"/> > maximum		
aspirin > 300 mg/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aspirin + codeine/dihydrocodeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aspirin/NSAID-containing cough/cold/sinus preparation		<input type="checkbox"/>	
oral NSAID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral NSAID + codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
topical NSAID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tramadol		<input type="checkbox"/>	
other opioid		<input type="checkbox"/>	
other analgesic		<input type="checkbox"/>	

13. Was the analgesic **requested** recommended by *Guidelines* for the presenting problem? (See Q8a)
 yes no no guidance not requested

14. Was the analgesic **supplied** recommended by *Guidelines* for the presenting problem? (See Q8a)
 yes no ▼ no guidance not supplied

Reason for supply:

- recommended analgesic tried but not found to be effective
- patient expressed preference
- doctor recommended
- not appropriate for this patient, e.g. coexisting condition, interacting drugs
- other (specify) _____

15. The following were discussed with the patient:

- overall pain management ▶ consider non-drug therapies such as RICE
- optimum dosage of drug therapy ▶ confirm dosage of recommended and concurrent drug therapy
- avoid exceeding maximum daily dose of analgesia ▶ confirm maximum daily doses, especially for paracetamol
- potential for drug interaction ▶ confirm medication use and consider implications of interaction
- need for antihistamine-containing preparation ▶ generally avoid (see *Guide*)
- bowel health (for opioid containing products) ▶ maintain fluid, diet and mobility. Consider regular laxative use
- optimum patient compliance with supplied drug therapy ▶ advise about correct use, frequency, dosing and adverse effects
- written supporting materials ▶ supply appropriate materials (see *Guide*)
- referral to GP for further management ▶ a written advice/referral note is preferred

Next

Section E: Self-assessment

16. Did Section A indicate that a pharmacist should talk to the customer?

- yes no

17. Which staff member/s were involved with this customer?

- pharmacist pharmacy assistant
 pre-registration pharmacist pharmacy student

18. Barriers to optimum quality of care: (mark all that apply)

- none customer in a hurry
 customer unreceptive to questioning lack of private counselling area
 customer was not the patient pharmacist too busy
 other (specify) _____

19. On a scale of 1–4, how would you rate:

1 = Needs improvement 2 = Good 3 = Very good 4 = Excellent

a) your ability to gather information from this customer?

- 1 2 3 4

b) your ability to explain the benefits and risks of analgesic therapy?

- 1 2 3 4

c) your ability to answer any questions from this customer?

- 1 2 3 4

d) the overall quality of your interaction with this customer?

- 1 2 3 4

e) your confidence to refer to the GP?

- 1 2 3 4



National Prescribing Service Limited

Pharmacy practice audit enrolment

Pharmacy practice audit: Optimising the use of OTC analgesics

Why an audit on over the counter (OTC) analgesics?

Improving the use of OTC analgesics contributes to the overall management of pain. Pharmacists and pharmacy staff play an important role in advising patients on the appropriate choice and use of analgesics.

Participation in this audit provides you with an opportunity to:

- optimise the safe and effective use of OTC analgesics by recommending a step-wise approach to self management of pain
- identify patients who have a contraindication to, or the potential for drug interactions with, an analgesic
- ensure internal systems for referral are functioning appropriately
- demonstrate provision of quality care
- assist with staff education.



The Pharmacy Guild of Australia



This program is recognised by professional pharmacy bodies as follows:
 PSA CPD & PI Program and AACP (8 credit points)
 PGA QCPP/CQI (1 point under 1st edition)
 SHPA personal CPD record (4 hours).

To order your free audit kit

- Fax (02) 9211 7579 OR Post to: Locked Bag 4888 Strawberry Hills NSW 2012
- Enrol before Friday, 27 October 2006.

Your audit must be completed and returned by **Friday, 1 December 2006**.

To see a sample audit form before enrolling, visit www.nps.org.au/healthpro

For more information contact Sheena O’Riordan or Clare Bottomley phone (02) 8217 8700, email info@nps.org.au

Your details: *Please use BLOCK LETTERS*

Title Family name

Given names

Postal address

Town or Suburb

State or Territory Postcode Phone no. ()

Registered pharmacist PSA No. ▶ required for CPD & PI points

I would be interested in participating in development of NPS pharmacy practice audits and other activities.

Pre-registration pharmacist

NPS adheres to the National Privacy Principles contained in the Privacy Act 1988 (Cwth). All personal information collected by NPS will be used only for mailing of NPS materials relating to this audit and/or evaluation purposes.

NPS is an independent, non-profit organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

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