THE INFO BELOW IS FROM THE VARIOUS MORNING WORKSHOPS ON THE COV AND WARWICKS VTS INTRO COURSE SEPT 16TH 2011

Doctor's Bag

1. **Have you all got a Doctor's Bag, and if so, what's in your bag?**

2. **What 3 issues are important to consider when owning a Doctor's bag?**
   Lockable Bag
   Checking in Date drugs
   Storing bag at appropriate temperature - between 4° and 25°C

3. **What equipment is desirable to have in one's bag?**

- Local A to Z map or sat nav!
- Stationery - a limited number of FP10 (prescriptions), sick-notes, headed letter paper, compliments slips, and envelopes.
- Mobile phone & pre-programmed numbers for ambulance, local hospital, practice and Trainer.
- British National Formulary.
- Large-volume spacer (e.g. Aerochamber).
- Alcohol wipes, gloves, K-Y jelly .
- Personal alarm - several versions are readily available. The police suggest that when used, an alarm is thrown about 10-20 feet to cause distraction.
- BP machine
- Ophthalmoscope/Auroscope
- Stethoscope
- Reflex hammer
- Hand decontamination products
- Multistix
- Glucometer with lancets and in date test strips
- Tongue depressors, preferably wrapped.
- Small torch
- Additional stationery, investigation forms etc.
- Peak flow meter, preferably low-reading.
- Syringes, needles, and tourniquet
- Venflons

4. **What drugs should you carry?**
   NB The following list is taken from the DTB at a time when GPs did their own OOH. As a result, some of the drugs are no longer necessary. There is no right or wrong answer; you

need to balance up need vs cost/time for checking etc. What could you reasonably administer before an ambulance arrived?

- Analgesia
- Paracetamol - 120mg/5ml and 250mg/5ml oral suspensions, 500mg tablets.
- Ibuprofen - 100mg/5ml oral suspension , 400mg tablets.
- Codeine - 25mg in 5ml syrup, 30mg tablets.
- Morphine - 10mg/5ml oral solution, 10mg/ml injection OR Tramadol as an alternative.
- Diamorphine - 5mg or 10mg (powder for reconstitution with water for injection) OR Tramadol as an alternative.
- Diclofenac - 25mg/ml injection, 12.5mg and 100mg suppositories.
- Diazepam - 5mg tablets (for muscle spasm)
- Naloxone - 400micrograms/ml injection (to reverse opioid overdose).

- Antimicrobials
- Benzylpenicillin - 600mg vial for reconstitution with sodium chloride or water for injection.
- Cefotaxime - 1g vial reconstituted with water for injection.
- Chloramphenicol - 1g vial reconstituted in water for injection.
- Amoxycillin - 125mg/ml and 250mg/5ml oral suspension, 250mg capsules.
- Erythromycin - 125mg/5ml and 250mg/5ml suspensions, 250mg tablets.
- Clarithromycin - 125mg/5ml and 250mg/5ml suspensions, 250mg tablets.
- Trimethoprim - 50mg/5ml suspension, 200mg tablets.
- Cefalexin - 125mg/5ml and 250mg/5ml suspension, 250mg capsules.
- Flucloxacillin - 125mg/5ml and 250mg/5ml suspensions, 250mg tablets.
- Aciclovir - 800mg tablets.
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- Asthma
- A short-acting beta-agonist - Salbutamol MDI 1mg
- Prednisolone - 5mg soluble tablets.
- Oxygen - delivered via a close-fitting face mask or nasal prongs.
- Ipratropium - 250micrograms/ml nebuliser solution.
- Hydrocortisone - 100mg powder as sodium succinate for reconstitution with water for injection (also useful for anaphylactic shock, adrenal crises).
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- Rehydration
- Oral Rehydration Salts - Dioralyte or Electrolade sachets.

- Diabetic Hypoglycaemia
- Glucogel - 40% dextrose ampoules.
- Glucagon - 1mg/ml injection.
- Intravenous Glucose - 25ml ampoules (5% and 20%)

- Seizures
- Rectal diazepam - 2mg/ml and 4mg/ml strengths in a 2.5ml rectal application tube.[7]
- Midazolam - 5mg/ml, 2ml ampoule given bucally via a syringe (unlicensed route).[7]

- Lorazepam- 4mg/ml injection.

- Anaphylaxis
- Adrenaline - 1mg/ml ampoules, i.e. 1:1,000.
- Chlorphenamine - 4mg tablets, 2mg/5ml syrup, 10mg/ml ampoules for injection.
- Sodium chloride - 0.9%, 500ml via giving set.

- Nausea and Vomiting
- Domperidone - 1mg/ml suspension, 10mg tablets, 30mg suppositories.
- Prochlorperazine 5mg/ml syrup, 5mg tablets, 5mg and 25mg suppositories, 12.5mg/m injection.
- Cyclizine - 50mg/5ml mixture, 50mg tablets, 50mg/ml injection.
- Procyclidine - (to reverse oculogyric crises) 5mg/ml injection.
- Metoclopramide - 1mg/ml paediatric liquid, 5mg/5ml elixir, 10mg tablets, 5mg/ml injections.

- Myocardial infarction and angina
- Aspirin - 75mg tablets (give two).
- Glyceryl trinitrate spray - 400micrograms/metered dose spray.
- Atropine - 600micrograms/ml injection for bradycardia.

- Acute Left Ventricular Failure
- Furosemide - 10mg/ml injection, 20-50mg by slow IV injection. Also useful to have 40mg tablets available for less severe CCF.

- Post-partum Haemorrhage
- Syntometrine - ergometrine maleate 500micrograms plus oxytocin 5units/ml injection.

- Psychiatric Emergencies
- Haloperidol - 1.5mg tablets, 5mg/ml injection.[9 10]
- Lorazepam - 1mg tablets, 4mg/ml injections.
- Flumazenil - 100micrograms/ml injection to reverse respiratory depression caused by lorazepam.

5. Is your decision affected by where your practice is based?

Practice location is very important as rural practices are likely to need more extensive drugs and possibly oxygen, as ambulances will take longer to get to them. City practices are more fortunate.

Flu Season

It's coming round to that time of year when flu vaccines need to be administered. It is quite a significant addition to a GP's workload and therefore, needs to be done as systematically as possible.

1. **Which groups of patients are entitled to receive a flu vaccine?**

   Are 65 years of age or over

   Are pregnant

   Have a serious, chronic medical condition (Asthma, COPD, CHD, CKD, DM, Liver disease, HIV, Immunosuppressed)

   On immunosuppressants/undergoing chemotherapy

   Are living in a long-stay residential care home or other long-stay care facility (not including prisons, young offender institutions or university halls of residence)

   Are the main carer for an elderly or disabled person whose welfare may be at risk if you fall ill

   Are a frontline health or social care worker

2. **Who should have a pneumococcal vaccine? How often is it administered?**

   All of above. Only needs to be administered once in their lifetime, unless they are immunocompromised.

Look at the following League Table. You are the Practice at the bottom of the table (not in performance order).....

3. **What do you think about last year's performance?**

   Poor performance in both fields comparative to the rest of the city.

WHO targets:

>65 yrs	70%
<65 yrs at risk	60%

4. **Can you think of any possible reasons why these figures might be so low?**
   Poor patient education
   Lack of flexibility of appointments for flu vaccines – particularly hard for working population
   Inadequate practice advertisement of flu season
   No systematic approach

5. **What are the implications on the practice of having such poor figures?**
   Cost – payment of £X per vaccine received.
   Patient health – increased risk of significant mortality and morbidity in vulnerable groups.
   Pride within the city – will this affect other GPs' opinion of you?

6. **How can you improve your figures this year? What is going to be your approach to this year's flu season?**
   The key is to approach this systematically
   Start by ensuring your surgery adequately advertises flu season – on prescriptions, in the waiting room, on your website etc.
   Look at your patient groups which need vaccinating....
   Are they on medication? How often do you see them for medication reviews?
   Although the vaccines wont have arrived for at least another few weeks, you could start discussing the importance of having a flu vaccine with these patients when you see them routinely.
   Are you likely to see some of these patients opportunistically over this period?
   Can you flag the notes to remind yourself to vaccinate these patients?
   Are you going to arrange some flu clinics? When should these be run and by whom? How many patients can you safely administer in one minute?
   When are you going to review your figures? It's sensible to have an eye on how well you are doing and review this every couple of weeks. By looking at these

figures, you might find you need to open on a Saturday morning so that working patients can attend.

Whilst doing all of the above, you need to keep on top of your vaccine stocks, so that you don't run out, but equally, don't get left with a fridge full of unused vaccines!

Looking After Ourselves

Do healthcare professionals receive better or worse care than the rest of the public?

Much worse care!

We don't make appointments to see our GP

We self treat and medicate

We have corridor consultations with our colleagues

We risk being over or under treated inappropriately

What about when we see healthcare professionals as patients? Do we manage them any differently?

What do we all do to protect ourselves from becoming unwell?

Work life balance etc

Everyone give an example

What do we do if we are worried about our management of a patient?

But why are medics more prone to certain illnesses, such as depression and alcoholism?

Type A personalities

Macho culture of medical school and doctors

Dealing with horrendous problems

Stigma of illness

Taking on patients' emotional problems/burnout

Self Medicating

What are your views on the scenarios below. Which, if any, are acceptable?

- You have been unwell for a week, coughing up green sputum. Is it alright to prescribe yourself some amoxycillin?

- You are sleeping very badly and feeling chronically tired. Is it OK to prescribe yourself 20 diazepam?

- You are getting a lot of back pain. Paracetamol isn't working and you decide to try dihydrocodeine. Is this OK? Should you write your own prescription or should you ask a mate to sign it for you?

- You think you might well be depressed and decide to try fluoxetine

- Your 3 year old is ill with earache and you write her a prescription for amoxycillin

- Your husband / wife has a weight problem and asks you for orlistat

None of these are acceptable.....

What are the implications if our colleagues are sick and how do we feel about this?

Our workload increases. Less likely to be sympathetic etc.

What signs would suggest a colleague is becoming unwell?

Poor time management, running behind in surgery

Missing surgeries for appointments or calling in sick, where appts needing to be cancelled at short notice

Complaining of difficult patients

Lack of sympathy for patients/increased complaints

Not socialising

Poor efficiency with paperwork etc

Difficult during meetings – more tearful, aggressive etc

And how do you feel about this as a colleague?

Where can we go to if we start to feel unwell?

Our own GP

Occupational health

Sick Doctors (BMA)

TELEPHONE CONSULTING

Advantages

Time saving

Triage out the inappropriate

Drawbacks

Loss of visual cues

Unable to see physical signs

Different consultation style?

Less control?

Confidentiality

More likely to be conflicting agendas

Accents/speed of speech/poor lines

Loss of “human elements” eg eye contact, touch

Skills required

Listening beware of jumping ahead

We THINK at 500 words/min

We HEAR at 300 words/min

We SPEAK at 125-150 words/min

Speaking

85% of telephone communication is conveyed through tone of voice

15% through actual words

Problem solving

Knowledge/resources

Factors which interfere with good telephone consulting

Environment - Noise, Distractions

Mental side trips (easier to drift away from concentrating)

Inadequate safety netting

Over-reliance on the caller

Being dismissive

Over-reliance on previous consultation

Premature closure

It's your responsibilty to gte the information, not the caller's to give it

3rd parties

Failure to document – should have:

- Date and time
- Clinical details
- Management plan
- Self care information given
- Safety netting advice

TELEPHONE CONSULTING

1. **Why do we use the phone in GP rather than just see patients at an appointment?**
2. **What are the drawbacks of telephone consulting?**
3. **What specific skills are required?**
4. **What factors can and do interfere with good telephone consulting?**

Consider the following scenario:

You are the duty doctor for the practice this afternoon. There are no appointments left and you are already running ½ hr late and have a home visit to do.

The receptionist asks you to call back Miss SP a 56yr old lady who lives in one of the villages 5 miles out of town (in the opposite direction to you already planned visit). She has called distressed requesting a visit because she has heavy vaginal bleeding.

What are the key considerations that you might like to make before making this call?

What are the main points in the history that you need to establish?

What strategies can be useful in persuading a patient to come in to be seen rather than just going out to do the visit?

Considerations

You are almost certainly already stressed and this is likely to affect both your active listening skills and tone of voice

Your own pressures may lead you into making a bad decision whether to go out or not

This may be something trivial but could (more rarely potentially be a life threatening problem)

The patient is distressed and probably scared, she may not be able to give a clear history and is likely to need some time to be able to give sufficient information

Worth checking her notes for PMH, consultation pattern etc. We can all get caught out but if this is someone we rarely see then that is sometimes significant

History

Gynae hx

Type, duration and if possible some idea of volume of bleeding (usually difficult to assess)

Haemodynamics any sob, palpitations, faint symptoms etc

Is she on her own

Transport/ability TCI

Strategies

“If you come up now, I can see you pretty well straight away…”

“We have all the equipment in the surgery to enable me to make a full examination and assessment of your condition and this would be difficult at home”

And for the dependent ones. “Well I could see you if you come in but it wont be me if you need a HV!”

MANAGING UNCERTAINTY

"Science does not give us absolute and final certainty. It only gives us assurance

within the limits of our mental abilities and the prevailing state of scientific thought"-

Ludwig von Mises

"GPs tolerate uncertainty, explore probablility and marginalise danger. Hospital specialists work towards reducing uncertainty, exploring possibility and marginalising error"

Marinker

Safety netting

Things you can say:

"Come back if…"

"Ring me if…"

"I'll ring you …"

"If… then …otherwise…" instructions

Strategies for dealing with uncertainty

Revisit the history

Re-examine the patient

Do more tests (rarely helpful, often increases uncertainty and anxiety)

Arrange a follow up

Discuss with colleagues

Play percentages; accept probability rather than certainty

Not all decisions are either/or

Diseases are not uni-causal not all management follows algorithms

Separate the knowns, from the unknowns

Deal with Risk

1. Avoid it - Not really recommended but can be used
   -Refer everyone

   -Bring every patient back for review

   -Treat everyone

   -Escape to another speciality (Non clinical)

2. Accept Risk - Accept responsibility

Anxiety

Anxiety is infectious - Anxious patients can make anxious doctors and vice versa

Is there a good cause for anxiety or are the patients perceptions out of line with reality?

Is the diagnosis anxiety?

Separate the zebra from the horses

Common diseases occur commonly and rare disease occur rarely

The mind is an imperfect estimator of risk

The unusual presentation of a common disease is generally more unlikely than the usual

presentation of an uncommon disease

Not everything we are taught is correct.

MANAGING UNCERTAINTY

Case scenario

30 year old woman presents with recurrent headaches

No red flags or worrying symptoms, nothing to find on examination

Sound like classical tension headaches

Lives with partner and 2 children, works part-time as a receptionist

Financial worries and debts, partner's job not secure

Smokes 20pd, drinks alcohol occasionally

Otherwise fit and well, slightly overweight, no regular exercise

IUD for contraception

Mother has a history of hypertension and father has NIDDM

She is very worried about the headaches, you are the 3rd doctor she has seen about them in the last 8 weeks

She would like a brain scan

1. What are the issues here
   For the patient?

   For the doctor?

2. What strategies might you use in this consultation? (think ICE)

3. What do we mean by safety netting?
    a. What phrases do you use when safety netting?
    b. What specific things might you want to consider here (follow up etc)?

4. How do you personally deal with uncertainty and how will you manage this in your career in GP (It is important you consider this for yourself even if this isn't discussed in the group)