**Facilitator Notes**

**Martin Shuttleworth, aged 50-55**

This is a scenario where the patient has been in hospital for 3 weeks with a chest infection and irregular heartbeat he has been asked to come to see the GP to discuss his medication. The patient has some information from a Discharge Advice Note but this does not fit in with the patients records. The students will focus on the consultation skills shown in particular the checking of understanding and management plan agreement. The second is about issues of communication with secondary care.

**Character and background**

Martin is currently not working due to ill health , he had a big heart attack a year ago and was working as a warehouseman before that, grown up family, divorced lives on own. Ex-smoker 1 year still drinks beer 6-8 pints a day Saturday and Sunday only. Average education, is worried about health but still has a drink and takes no exercise and is quite shocked to now be on warfarin. Has a lot of faith in his GP practice but is a bit confused by the hospital. He really wants the practice just to sort it all out for him and then explain to him just what he needs to do. Very willing to be concordant but lacks information.

**The Consultation**

Mr Shuttleworth asked for a repeat of his medication and someone to check his warfarin levels but has been asked to attend as there is confusion as to what he should be taking. The GP has a Discharge Advice Note but the reasons for change are not obvious on the sheet. Mr Shuttleworth cannot remember first week in hospital, collapsed at daughters after a week of a flu like illness and was told had pneumonia and an irregular heartbeat. Infection settled but still palpitations so medication changed around and warfarin started.

Was on

* Atorvastatin 80mg
* Sol aspirin 75mg
* Bisoprolol 5mg
* Ramipril 5mg
* Amlodipine 10mg
* Now has note stating on [will write a proper looking note for later]
* Atorvastatin 40mg
* Bisoprolol 12.5 mg
* Ramipril 2.5 mg
* Half-Securon SR 120mg
* Furosemide 40mg
* Warfarin 5mg

He feels a bit tired and dizzy [no rotation just a bit faint feeling], not breathless at rest and hasn’t really done anything since home, 16 year old granddaughter staying with him to look after him, no pain, no ankle swelling.

GP explains has rung hospital but the FY1 doctor is off today and the notes are in transit.

Checks pulse and BP which are both a bit low, and explains rationale for change. Mr Shuttleworth wants to know why hospital have “got it wrong”

GP will arrange for follow up by warfarin clinic and fax changes to consultant secretary and follow up with a phone call.

GP safety nets re patient symptom and when should have heard from hospital . Follow up appointment for nurse re BP and pulse 2 days.

**Scenario 2: Points of Interest**

Timeline

Initial opening statement open questions “what do you mean by flu”

1.00 how does the relationship rapport differ from first les computr more eye contact

2.05 explanation started

3.30 GP will sort it out , already possibly defending hospital

4.10 communication and handovers

4.40 “unusual “ code for bizarrely dangerous

5.40 lots of “noddies”

7.00 use of mobile phones

7.25 total heart block due to verapamil beta blocker ? should admit

8.50 has someone at home

9.10 ? LVF nocturia as part of this

9.40 aspirin and Warfarin

10.50 half –securon , use of branded drugs

12.30 FY discharge letters

12.50 Warfarin clinics

1450 checks understanding?

**Learning and discussion points**

1. What sources of information can be used to account for unexplained medicine changes on discharge from hospital?
2. A medicine reconciliation aims to identify changes in medicines and doses. Not all changes can be accounted for and the GP needs to make a decision about what should be continued. How did the GP make a professional decision to continue the prescribing given limited information? Was this a good decision?
3. The GPs aim from the consultation was to obtain more information about the medicines so that an accurate repeat prescription could be written. What were the patient’s needs form the consultation. Were these met?

How far do we cover for professionals is this a “serious incident” responsibility for prescriptions lies with who?