Individual Therapeutic-plan Discussion

Experiment 3 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To compare treatment options and justify a proposed patient-specific plan.

Principle

An appropriate plan considers indication, evidence, patient factors, feasibility and monitoring rather than choosing a medicine solely from a disease name.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm therapeutic objective; allergies and contraindication questions; renal/hepatic function and interactions; available local guideline and patient preference. Note missing information explicitly.

3. Develop the pharmacy assessment

Create an option table with expected benefit, relevant risk, feasibility and monitoring. State why an option is proposed and what information must be confirmed. Present dose/route/duration checks from the current approved patient-specific method to the treating team; do not implement an unapproved student plan.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded case and date	_____
Presenting problem and diagnosis	_____
Allergies / previous medicines	_____
Relevant clinical and laboratory findings	_____
Pharmacy problem and priority	_____
Proposed plan and monitoring	_____
Supervisor decision and follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. What makes a plan individualised?

It uses the patient-specific goal, risks, treatment context and follow-up requirements.

2. What if a key clinical fact is missing?

State the uncertainty and obtain it before recommending a dependent action.

Disease-area Checklist

Area	Topics	Assessment focus
Infectious diseases	Rational antimicrobial use and surgical prophylaxis; TB, meningitis, respiratory/GI infections, endocarditis, sepsis, UTI, malaria, HIV/opportunistic infections, fungal/viral infections, gonorrhoea and syphilis.	Indication, microbiology evidence, source/site, allergy, renal/hepatic function, duration and review plan.
Musculoskeletal	Rheumatoid arthritis, osteoarthritis, gout, spondylitis and systemic lupus erythematosus.	Symptoms/function, comorbidities, medicine risks and required safety monitoring.
Renal	Acute/chronic kidney failure, dialysis and drug-induced renal disorders.	Renal trend, urine/volume context, dialysis schedule and medicine-review needs.
Oncology	Cancer-treatment principles, breast cancer, leukaemia and chemotherapy-related nausea/emesis.	Regimen documentation, protocol checks, supportive care, interactions and urgent toxicity escalation.
Dermatology	Psoriasis, scabies, eczema and impetigo.	Diagnosis/site, topical application technique, adherence and review of response.

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