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</table>
Prescribing Safety Assessment

The Prescribing Safety Assessment (PSA) has been developed by MSC Assessment and the British Pharmacological Society as a summative assessment of knowledge, judgement and skills related to prescribing medicines in the NHS. It is intended primarily for medical students at or near the end of their training and is based on competencies identified by the General Medical Council in Outcomes for graduates (2018) (originally published in Tomorrow’s Doctors (2009)). These competencies include writing new prescriptions, reviewing existing prescriptions, calculating drug doses, identifying and avoiding both adverse drug reactions and medication errors, and amending prescribing to suit individual patient circumstances. The PSA is delivered as an on-line assessment. It assesses, as far as is possible within the confines of a virtual environment, complex skills including powers of deduction and problem-solving that are relevant to the work of Foundation (Year 1) doctors in the NHS.

Assessment structure

The assessment comprises eight sections (Figure 1), each containing a specific item style. There are either six or eight individual items in each section (Table 1). The assessment offers a total of 200 marks and candidates are normally expected to complete it within a total of two hours of examination time.

Figure 1. Basic structure of the Prescribing Safety Assessment (PSA)
The 8 styles of item assess prescribing, prescription chart review, planning management, providing important information to patients, calculation skills, adverse drug reactions, monitoring therapy and data interpretation. The item styles reflect not only the process of prescribing but also the related skills, judgement and knowledge required to review, advise and provide information about medicines. The skills assessed reflect the requirements of Outcomes for graduates (2018) and the recommendations of the Medical Schools Council Safe Prescribing Working Group (2007) about the competency requirements of Foundation doctors. The objectives of each item style and how to create them are described in more detail below.

Table 1. PSA sections and mark allocation.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Marks</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prescribing</td>
<td>80</td>
<td>8 items of 10 marks each</td>
</tr>
<tr>
<td>2</td>
<td>Prescription Review</td>
<td>32</td>
<td>8 items of 4 marks each</td>
</tr>
<tr>
<td>3</td>
<td>Planning Management</td>
<td>16</td>
<td>8 items of 2 marks each</td>
</tr>
<tr>
<td>4</td>
<td>Providing Information</td>
<td>12</td>
<td>6 items of 2 marks each</td>
</tr>
<tr>
<td>5</td>
<td>Calculation Skills</td>
<td>16</td>
<td>8 items of 2 marks each</td>
</tr>
<tr>
<td>6</td>
<td>Adverse Drug Reactions</td>
<td>16</td>
<td>8 items of 2 marks each</td>
</tr>
<tr>
<td>7</td>
<td>Drug Monitoring</td>
<td>16</td>
<td>8 items of 2 marks each</td>
</tr>
<tr>
<td>8</td>
<td>Data Interpretation</td>
<td>12</td>
<td>6 items of 2 marks each</td>
</tr>
<tr>
<td>TOTAL MARKS</td>
<td></td>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

The PSA blueprint identifies 7 settings of clinical activity into which the 8 item styles are set. The minimum number of relevant items from each setting in each assessment is shown in Table 2.

Table 2. Coverage of clinical settings

<table>
<thead>
<tr>
<th>Clinical setting</th>
<th>Minimum number of items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>8</td>
</tr>
<tr>
<td>Surgery</td>
<td>4</td>
</tr>
<tr>
<td>Elderly care</td>
<td>8</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>4</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>4</td>
</tr>
<tr>
<td>General Practice</td>
<td>8</td>
</tr>
</tbody>
</table>

Coverage of high-risk drug areas

Each PSA includes at least two items on each of the drug groups listed in Table 3.

These drug groups are included on the basis that they were identified by the National Patient Safety Agency (now part of NHS Improvement) as one of the 8 high risk prescribing categories most commonly associated with severe harm or death. Drugs in the other 3 categories (anaesthetics, chemotherapy and antipsychotics) are omitted on the basis that foundation doctors would not routinely have responsibility for prescribing these agents.
### Table 3. Therapeutic groups of drugs that are included in all Prescribing Safety Assessments

<table>
<thead>
<tr>
<th>Therapeutic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates</td>
</tr>
<tr>
<td>Anticoagulants</td>
</tr>
<tr>
<td>Insulins</td>
</tr>
<tr>
<td>Antibiotics</td>
</tr>
<tr>
<td>Infusion fluids</td>
</tr>
</tbody>
</table>

### Purpose of the assessment

The PSA is intended to assess basic competence in relation to:

- core knowledge about common medicines
- basic problem-solving skills related to medicines
- judicious selection and prescription of common medicines
- treatment of common clinical conditions
- management of common medical emergencies
- review of prescriptions made by other prescribers
- calculation skills

The PSA is not meant to assess:

- the ability to investigate or diagnose medical conditions

### General advice about PSA item writing

The following general advice relates to writing any PSA item style:

- Base items on clinical scenarios of a kind that a Foundation doctor can expect to face.
- Avoid using over-elaborate clinical scenarios containing excessive amounts of information, which require skills beyond those being assessed.
- Use the *British National Formulary*, to which candidates will have access during the assessment, as the ultimate arbiter of indications, dose ranges, adverse effects, interactions, etc.
- Use the item templates and writing manual guidance as far as possible: the PSA is a time-limited assessment and candidates must be confident that each item will appear in a familiar and consistent style.
- Provide clear feedback/justification for the answer to each item: this is absolutely essential for the quality assurance process, any appeals, and for the use of items in formative assessments.

### Creating PSA items using the on-line authoring software

On-line authoring software facilitates creation of PSA items in the required format. The website is available at [https://beta.admin.prescribingsafetyassessment.ac.uk](https://beta.admin.prescribingsafetyassessment.ac.uk)

Authors should log in using their unique username and password. The website provides guidance on house style and other matters that are described in full here.
Writing specific PSA Items

Prescribing (PWS) items
The Prescribing section comprises eight items, each of which requires the prescribing of a single drug/intravenous fluid in response to a clinical scenario. Each of the eight items is worth 10 marks (making a total of 80 marks for this item style).

Reasoning and judgement required. Deciding on the most appropriate prescription (drug, dose, route and frequency) to write, based on the clinical circumstances and supplementary information.

Measurable action to be assessed. Writing a safe, effective and legal prescription for a single medicine, using the documentation provided, to tackle a specific indication highlighted by the question.

Content. This item style presents a clinical scenario followed by a request to prescribe a single appropriate medicine or intravenous fluid. It is distinguished from other item styles by the specific requirement to write a prescription on one of a variety of prescription forms. Typical scenarios involve the treatment of acute conditions (e.g. acute asthma attack, acute heart failure), chronic conditions (e.g. depression, reflux oesophagitis) and important symptoms such as pain. The candidate must exercise judgement when deciding between different drugs, different formulations, different routes, different doses, and different dose intervals. It is expected that prescriptions should meet appropriate standards: they must be unambiguous and complete [correct drug and dosage form, correct dose, route and frequency]. In line with modern electronic prescribing systems, the prescription will be automatically signed and date/time stamped.

The duration of treatment (e.g. 7 or 28 days) should be included on all General Practitioner forms as there is no facility for the candidate to specify a quantity to supply.

Good Prescribing items should:
• avoid using over-elaborate clinical scenarios containing excessive amounts of information
• state clearly the symptom or problem to be addressed by the prescription within the ‘Prescribing Request’ box
• if an intravenous fluid is required, have a mark scheme that complies with NICE Guidance CG174 Dec 2013, or NICE Guidance NG29 Dec 2015, where clinically appropriate
• require only one prescription to be written.

Each of the items should contain a prescribing request following the style:
“Write a prescription for ONE drug that is most appropriate to [treat/alleviate/prevent] [symptom or problem].
( use the ['once only'/'regular medicines'/'hospital IV fluid'/'general practice'] prescription form provided)
Prescribing items are each scored out of a total of 10 marks, including 5 marks for drug choice and 5 marks for the dosage (dose/route/frequency). In recommending a marking scheme, authors are expected to acknowledge that there will often be more than one optimal answer for any prescribing task and sub-optimal answers may also deserve some credit (see example marking scheme overleaf).

The allocation of 5 marks is given for an optimal drug with the opportunity to reduce this to 4, 3, 2 or 1 for suboptimal answers. Reasons why an answer might be considered suboptimal include clinical effectiveness, relevant published guidance, practicality, availability in the relevant clinical setting, likely tolerability, likely adherence, and potential for drug interactions. Scoring will normally be restricted to drugs with a recognised indication for the condition being treated.

Once the score for the drug selection out of 5 has been decided, that same score becomes the maximum possible for the dosage option. In the same way as for the suboptimal selection of drug, there will be a stepwise deduction of marks for suboptimal expressions of dose, route or frequency. All marks for dosage will be lost for doses, routes or frequencies that are ineffective or dangerous.

A number of pre-prepared mark schemes (drug sets) are available within the online authoring system for adaptation and use in Prescribing items. Before creating a new marking scheme for a PWS item, check if a ‘drug set’ already exists in the relevant subject, by reviewing the drop-down list, while in edit mode.

Drug sets can be used as a basis for a mark scheme, but must be adapted to match the specific scenario, where appropriate.
## Model Prescribing item

<table>
<thead>
<tr>
<th>Style</th>
<th>ID</th>
<th>CS1</th>
<th>CK2</th>
<th>Diagnosis</th>
<th>BNF 1</th>
<th>BNF 2</th>
<th>Age</th>
<th>Sex</th>
<th>Last Edited</th>
<th>Author</th>
<th>QA</th>
<th>F&amp;C</th>
<th>DIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA</td>
<td>CPM</td>
<td>Hyper-sensitivity/allergy</td>
<td>3</td>
<td>19</td>
<td>M</td>
<td>20-08-2019</td>
<td>PSA Author</td>
<td>V0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Case presentation
A 19-year-old man presents to the GP with worsening breathlessness and a nocturnal cough. **PMH:** Eczema, allergic rhinitis, exercise-induced wheeze. **BM:** Gastroesophagael reflux disease, hypothyroidism. **Meds:** Montelukast 10 mg PO daily, fluticasone propionate 50 mcg INH Nazodone 10 mg PO bd, ibuprofen 400 mg PO daily, paracetamol 500 mg PO daily as required.

**On examination**
Temperature 37.4°C, HR 115/min and rhythm regular, BP 128/82 mmHg, RR 24/min. O2 sat 97%, breathing air. Able to talk in complete sentences. Wheeze on auscultation. **PEFR:** 430 L/min (50% of expected).

He is found to have a high probability of asthma and booked into the respiratory clinic for initiation of asthma control medication and a series of lung function tests.

### Prescribing request
Write a prescription for ONE drug that is most appropriate to prevent his nocturnal symptoms.

(Use the 'general practice' prescription item provided)

### Marking scheme for model Prescribing item

Selected drug groups and drug sentences:

1 to 12 of 12 records

<table>
<thead>
<tr>
<th>Drug Group Name</th>
<th>Drug Group Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beclometasone dipropionate</td>
<td>3</td>
</tr>
<tr>
<td>Budesonide (local)</td>
<td>5</td>
</tr>
<tr>
<td>Fluticasone propionate</td>
<td>5</td>
</tr>
<tr>
<td>Gliclazide</td>
<td>4</td>
</tr>
<tr>
<td>Montelukast</td>
<td>4</td>
</tr>
<tr>
<td>Formoterol/Budesonide</td>
<td>3</td>
</tr>
<tr>
<td>Salbutamol/Fluticasone propionate</td>
<td>3</td>
</tr>
<tr>
<td>Aminophylline</td>
<td>2</td>
</tr>
<tr>
<td>Zafirlukast</td>
<td>2</td>
</tr>
<tr>
<td>Sodium cromoglicate (local)</td>
<td>1</td>
</tr>
<tr>
<td>Prednisolone (systemic)</td>
<td>0</td>
</tr>
<tr>
<td>Salbutamol (local)</td>
<td>0</td>
</tr>
</tbody>
</table>
Prescription Review (REV) items

The Prescription Review section comprises eight items, each of which requires analysis of a list of currently prescribed drugs. Each of the eight items asks two questions and is worth 4 marks (making a total of 32 marks for this item style).

*Reasoning and judgement required.* Deciding which components of the current prescription are inappropriate, unsafe or ineffective for a patient based on their clinical circumstances.

*Measurable action to be assessed.* Identifying prescriptions (drugs, doses or routes) that are inappropriate, unsafe or ineffective from amongst the current list of prescribed medicines.

*Content.* This item style presents a scenario that requires review of a current list of prescribed medicines (e.g. an inpatient prescription chart, a referral letter from a general practitioner). Typically, this item style involves interpreting the list of medicines in light of a clinical problem (e.g. impaired renal function, loss of anticoagulant control, headache), spotting important drug interactions (e.g. verapamil with beta-blockers, erythromycin with warfarin), identifying obvious or serious dosing errors (e.g. morphine, digoxin, aspirin), or noting suboptimal prescriptions (e.g. loop diuretics prescribed to be given late in the day, ineffective doses). The number of medicines listed in each Prescription Review item should range from 6 to 10. Some knowledge of common effects, adverse reactions and interactions of common medicines will be assumed. Candidates should have time to consult the BNF for relevant information that might be considered beyond the core knowledge base of a minimally competent Foundation doctor.

Good Prescription Review items should:

- state clearly in each of two questions associated with the list of prescribed medicines the reason why between 1 and 3 prescriptions need to be identified
- ask the candidate to identify medicines that contain dosing errors, or are causing symptoms, contra-indicated, likely to interact, etc
- contain a maximum of ONE dosing error (unless the error involves the doses of two items in the list of prescribed medication being transposed)
- avoid questions asking which TWO drugs in the list of prescriptions interact with each other. Instead, include one of the interacting drugs in the lead-in (see Question B below).

Each of the items should follow the style:

‘Select the [ONE/TWO/THREE prescription/prescriptions] that [is/are] [most likely to be] [a cause of/contains a serious dosing error/interact/contra-indicated, etc.]. (mark [it/them] with a tick in column [A/B])’
# Model Prescription Review item

<table>
<thead>
<tr>
<th>Case presentation</th>
<th>Question A: Select the THID prescriptions that are most likely to be a cause of his sore mouth. (mark them with a tick in column A).</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 57-year-old man is admitted to hospital with a lower respiratory tract infection, which is worsening, despite commencing a course of antibiotics. He also reports having a sore mouth. PRR, COPD, ischaemic heart disease, DM. In addition to clarithromycin 500 mg PO b.i.d. every day of a 7-day course, his current regular medicines are listed (right). CHL: CHL (1.5 g) q.d. for 14 days.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question B: Select the THID prescription that is most likely to interact with clarithromycin to cause telithromycin. (mark it with a tick in column B).</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Prescription</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td><strong>Dose</strong></td>
</tr>
<tr>
<td>amoxicillin</td>
<td>500 mg</td>
</tr>
<tr>
<td>aspirin</td>
<td>75 mg</td>
</tr>
<tr>
<td>beclomethasone dipropionate</td>
<td>200 micrograms</td>
</tr>
<tr>
<td>famotidine</td>
<td>40 mg</td>
</tr>
<tr>
<td>levothyroxine microtablets</td>
<td>30 mg</td>
</tr>
<tr>
<td>ranitidine</td>
<td>5 mg</td>
</tr>
<tr>
<td>salbutamol</td>
<td>50 micrograms</td>
</tr>
<tr>
<td>theophylline nasal tablets (theaflavine)</td>
<td>200 mg</td>
</tr>
</tbody>
</table>

**Justifications**

**Question A:**
Beclomethasone is an inhaled corticosteroid. Patients who use inhaled corticosteroids sometimes experience a sore mouth and throat because of the development of oral candidiasis as a result of local suppression of the cellular immune responses. Broad-spectrum antibiotics such as amoxicillin can also lead to overgrowth of candida in the mouth.

**Question B:**
Clarithromycin may increase the plasma levels of theophylline, potentially causing symptoms of toxicity including telithromycin.
Planning Management (MAN) items

The Planning Management section comprises eight items, each of which requires identification of the most appropriate management option from a list of five. Each of the eight items is worth 2 marks (making a total of 16 marks for this item style).

Reasoning and judgement required. Deciding which treatment would be most appropriate to manage a particular clinical situation.

Measurable action to be assessed. Selecting the most appropriate treatment based on individual patient circumstances.

Content. This item style presents a clinical scenario followed by a request to identify the most appropriate treatment that would be part of initial management. This involves selecting between options (medicines, fluids and sometimes other treatments) that would be of real benefit and others that would have neutral or harmful effects. The candidate must decide on the most appropriate treatment, based on symptoms, signs and investigations, from a list of five. Such treatment might be preventive, curative, symptomatic or palliative. The candidate should show that they are able to select treatment that is appropriate to individual patients. They should be aware of situations where it is inappropriate to treat and also of the role of non-drug therapies (e.g. physiotherapy, TENS machines for pain relief). Some of these scenarios may relate to the management of clinical toxicological emergencies. The likely diagnosis (or differential diagnosis) should be clear from the scenario but need not be identified, to reflect the fact that planning management is sometimes necessary when there remains a degree of uncertainty about the underlying diagnosis (e.g. dyspnoea, abdominal pain, reduced conscious level).

Good Planning Management items should:
- be based on a list of 5 management options from which the candidate will be required to select the most appropriate
- avoid using over-elaborate clinical scenarios containing excessive amounts of information
- contain sufficient information to allow a competent candidate to select the best option unambiguously
- contain 4 distracting options that, while plausible, are clearly less appropriate than the correct answers in relation to the clinical scenario.

Each of the items should follow the style:
‘Select the most appropriate management option at this stage.
(mark it with a tick)’
# Model Planning Management item

## Case presentation
A 70-year-old woman is admitted to hospital with worsening breathlessness and a cough productive of green sputum. PMH: Hypertension, BMI. Antihistamine 3 mg PO daily, sulbutamol 200 micrograms I&I as required, amoxycillin 500 mg PO b.i.d for 5 days. RR: Longstanding smoker.

### On examination
Temperature 38.4°C, HR 96/min and rhythm regular, BP 170/82 mmHg, RR 24/min, 
O₂ sat 96% breathing air. Respiratory examination reveals a widespread expiratory wheeze.

### Investigations
CXR shows hyper-expansion of the lung fields and some old scarring at the left apex.

## Question
Select the most appropriate management option at this stage. (mark if with a tick)

## Resources associated with this item
No resource has been associated with this item.

## MANAGEMENT OPTIONS

| A | albuterol 50 mg PO | ✔ |
| B | furosemide 50 mg IV | ✔ |
| C | hydrocortisone 100 mg IV | ✔ |
| D | oxygen 25% via a venturi mask | ✔ |
| E | salbutamol 5 mg Neb in air | ✔ |

## Answers

### Option A Justification
There are no indications, other than the raised blood pressure, for diuretic and the presence of worsening reversible airways obstruction would contra-indicate it in the acute situation.

### Option B Justification
There is no evidence of fluid overload or pulmonary oedema.

### Option C Justification
The likely diagnosis means that a short course of oral corticosteroids is indicated, but IV corticosteroid is not necessary given the modest severity of the exacerbation.

### Option D Justification
The likely diagnosis would make oxygen at this concentration potentially hazardous and the saturations suggest that it is unnecessary.

### Option E Justification
The clinical presentation strongly suggests that a diagnosis of COPD with infective exacerbation is most likely at this stage. The patient has a widespread wheeze and so a nebulised bronchodilator such as salbutamol would help to relieve this problem.
Providing Information (COM) items

The Providing Information section comprises six items, each of which requires identification of the most important piece of information from a list of five. Each of the six items is worth 2 marks (making a total of 12 marks for this item style).

*Reasoning and judgement required.* Deciding what is the most important piece of information that should be provided to patients (or their carers) to allow them to choose whether to take the medicine, and to enhance its safety and effectiveness.

*Measurable action to be assessed.* Selecting the information that is most important.

*Content.* This item style presents a brief scenario in which a patient is about to start taking a new treatment or has come to ask advice about an existing treatment. The candidate is expected to select the most important piece of information that they would provide to the patient from a list of 5 that includes four distractors.

Good Providing Information items should:

- be based on a clinical scenario in which a patient is about to start taking a medicine or has other reasons to ask for information that is relevant to its effectiveness and safety (the scenario might alternatively involve transfer of information to a carer or a professional colleague)
- be based on a list of 5 information options relating to the scenario, from which the candidate will be required to select the most important
- avoid over-elaborate clinical scenarios but contain sufficient information to allow a competent candidate to select the best option unambiguously
- contain 4 distracting options that, whilst plausible and (ideally) true, are clearly less important to give to the patient than the correct answer.
- express information options using patient-friendly language, avoiding medical and scientific jargon

Each of the items should follow the style:

‘Select the most important information option that should be provided for the [patient/mother/staff nurse/GP].
(mark it with a tick)’
## Model Providing Information item

<table>
<thead>
<tr>
<th>Style</th>
<th>ID</th>
<th>CS1</th>
<th>CS2</th>
<th>Diagnosis</th>
<th>BNF 1</th>
<th>BNF 2</th>
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<th>Sex</th>
<th>Last Edited</th>
<th>Author</th>
<th>QA</th>
<th>FAC</th>
<th>DIS</th>
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</thead>
<tbody>
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<td>Case presentation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
A 50-year-old man is assessed on the medical admissions unit for a suspected DVT in his left calf following recent orthopaedic surgery to his knee. Warfarin sodium 100 mg SC daily commenced on arrival.

**Investigations**

Duplex ultrasound scan confirms the presence of a DVT in the lower left leg. The patient is also found to have coagulation disorder.

**Question**

Select the most important information option that should be provided for the patient. (mark it with a tick)

- A: Warfarin sodium 3 mg tablets are blue
- B: Warfarin sodium is better tolerated if taken in the evening
- C: Warfarin sodium therapy reduces the risk of a second DVT
- D: Warfarin sodium may increase the risk of bleeding
- E: Weekly blood tests will be required throughout treatment

**Answers**

**Option A Justification**

All warfarin tablets (0.5 mg, 1 mg, 3 mg and 5 mg) are colour coded to aid recognition and estimation of dose. However, this is not the most important information to give to the patient.

**Option B Justification**

It is advisable to take warfarin at the same time each day to aid adherence to the treatment regime. For many patients, it is taken as an evening dose. The time of day does not, however, improve tolerability.

**Option C Justification**

Warfarin treatment will reduce the risk of a second DVT, but this information is not as important as warning the patient about the risk of bleeding.

**Option D Justification**

Warfarin is an anticoagulant that carries a significant risk of bleeding. This risk is reduced if the INR is regularly monitored.

**Option E Justification**

Frequent blood tests are necessary in the early weeks of treatment but once the results are stable the tests are required less often.

**Resources associated with this item**

No resource has been associated with this item.
Calculation Skills (CAL) items

The Calculation Skills section comprises eight items, each of which requires calculation of the correct figure based on a very brief clinical scenario. Each of the eight items is worth 2 marks (making a total of 16 marks for this item style).

Reasoning and judgement required. Making an accurate drug dosage calculation based on numerical information.

Measurable action to be assessed. Recording the answer accurately with appropriate units of measurement.

Content. This item style will present a scenario in which the candidate has to make an accurate calculation of the dose or rate of administration of a medicine. They must interpret the problem correctly and use basic arithmetic skills to derive the correct answer. Examples of potential scenarios might include identifying the correct amount of medicine to achieve a required dose, making necessary dose adjustments based on weight or body surface area, or diluting a drug for administration in an infusion pump. These items will also include testing the candidate’s ability to recognise and convert different expressions of drug doses and concentrations.

Good Calculation Skills items should:

• be based on a very brief clinical scenario that requires a calculation to be made in order to select a safe and effective dose or to plan the patient’s treatment in some other way
• include a minimum of clinical detail sufficient to put the calculation into context
• contain all the relevant numerical data with standard units
• be sufficiently complex that they may require the use of a calculator, and/or involve multiple steps to obtain the correct answer

These items may also contain reasonable distracting data that the competent candidate might need to reject as irrelevant to the calculation.

Each of the calculation requests should follow the style:
‘What [dose/volume/duration/rate etc.]/[(mL)/(mg)/(mL/h)/(tablets) etc.] of [name of the medicine] [should the patient take/is required etc.] [per dose/each day etc.] . . . (write your answer in the box provided)’

Model Calculation Skills item

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Case presentation:
A 3-month-old baby in the paediatric emergency department requires a dose of midazolam to be administered intramuscularly for status epilepticus. The dose of intramuscular midazolam is 300 micrograms/kg (max 2.5 mg), repeated once if necessary after 10 minutes. Weight: 6.8 kg.
Midazolam intramuscular solution is available as a 5 mg/mL solution.

Calculation:
What volume (mL) of midazolam intramuscular solution should the patient be given for the first dose?
(write your answer in the box provided)

Answer: 0.3 mL

Justifications

Working
The dose of midazolam is 300 micrograms x 5 = 1500 micrograms (1.5 mg).
The concentration of the solution available is 5 mg/mL.
Therefore, volume required = 1.5/5 mL = 0.3 mL
Adverse Drug Reaction (ADR) items

The Adverse Drug Reaction section comprises eight items (two of each type A–D), each of which requires identification of the most appropriate answer from a list of five. Each of the eight items is worth 2 marks (making a total of 16 marks for this item style).

*Reasoning and judgement required.* Identifying likely adverse reactions to specific drugs, drugs that are likely to be causing specific adverse drug reactions, or potentially dangerous drug interactions, and deciding on the best approach to managing a clinical presentation that results from the adverse effects of a drug.

*Measurable action to be assessed.* Selecting likely adverse reactions of specific drugs, selecting drugs to discontinue as they are likely causes of specific reactions, avoiding potential drug interactions and providing appropriate treatment for patients suffering an adverse event.

**Content – Type A items.** This item style requires the candidate to identify the most likely adverse effect of a specific drug. Examples might include the commonest adverse effect caused by commonly prescribed drugs, such as calcium channel blockers, beta2-agonists, non-steroidal anti-inflammatory drugs, aminoglycoside antibiotics, etc.

**Content – Type B items.** This item style requires the candidate to consider a presentation that could potentially be caused by an adverse drug reaction and identify the medicine most likely to have caused the presentation. Examples might include newly recognised renal impairment, hepatic dysfunction, hypokalaemia, urinary retention, etc.

**Content – Type C items.** This item style requires the candidate to consider a presentation resulting from a potential interaction between medicines currently being prescribed to a patient and identify the drug most likely to be clinically important. Examples might include interactions such as warfarin–statins, NSAIDs–ACE inhibitors, etc.

**Content – Type D items.** This item style requires the candidate to consider a clinical scenario in which a patient is suffering an adverse drug event and decide on the most appropriate course of action. Examples of adverse events might include acute anaphylaxis, excessive anticoagulation, drug-induced hypoglycaemia, diuretic-induced dehydration, etc.

Good Adverse Drug Reaction items should:

- be based on common adverse effects, so that competent candidates are not faced with the need to refer repeatedly to the British National Formulary
- be based on a list of 5 options (drugs/adverse effects/interactions/actions) relating to the scenario, from which the candidate will be required to select the most appropriate
- avoid over-elaborate clinical scenarios, but contain sufficient information to allow a competent candidate to select the best option unambiguously
- contain 4 distracting options that, while plausible, are clearly less appropriate than the correct answer in relation to the clinical scenario.
Each of the items should follow the style:
Type A – ‘Select the adverse effect that is most likely to be caused by this treatment. (mark it with a tick)’
Type B – ‘Select the prescription that is most likely to be contributing to the [insert adverse effect]. (mark it with a tick)’
Type C – ‘Select the prescription that is most likely to interact with [the drug specified in the stem] to [describe the clinical problem here]. (mark it with a tick)’
Type D – ‘Select the most appropriate option for the management of this adverse drug reaction. (mark it with a tick)’

Model Adverse Drug Reactions item

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Case presentation
A 67-year-old man has started to take morphine in 10 mg PO 4 hourly for pain associated with a gastric carcinoma.

Question
Select the adverse effect that is most likely to be caused by this treatment. (mark it with a tick)

Adverse Effect Options

A. Diarrhoea  
B. Nausea  
C. Palpitations  
D. Pruritis  
E. Sweating

Answers

Option A: Justification
Morphine is associated with constipation, not diarrhoea.

Option B: Justification
Morphine acts on opoid receptors in the brain to depress neurotransmission and potentially cause drowsiness.

Option C: Justification
Morphine is associated with the development of palpitations but this is a less common adverse effect than either diarrhoea or nausea.

Option D: Justification
Morphine is not associated with itching, although this symptom can occur following withdrawal of opioid treatment or opiate use.

Option E: Justification
Sweating and agitation are phenomena associated with withdrawal of opioid analgesics in dependent patients. They can occur as an adverse effect of morphine but less commonly than either diarrhoea or nausea.
Drug Monitoring (TDM) items

The Drug Monitoring section comprises eight items, each of which requires identification of the most appropriate answer from a list of five. Each of the eight items is worth 2 marks (making a total of 16 marks for this item style).

Reasoning and judgement required. Deciding on how to monitor the beneficial and harmful effects of medicines.

Measurable action to be assessed. Identifying the most appropriate method of assessing the success or failure of a therapeutic intervention.

Content. This item style presents a scenario that involves making judgements about how best to assess the impact of treatments that are ongoing or are being planned. Candidates are expected to demonstrate that they understand how to plan appropriate monitoring for beneficial and harmful effects, based on factors such as clinical history, examination and investigation. This may involve taking blood samples at the right time, deciding which measurement is likely to lead to the most appropriate assessment of outcome, or the timing of that measurement. Examples of prescriptions that might require appropriate monitoring are digoxin for atrial fibrillation, inhaled corticosteroids for asthma, oral contraception, levothyroxine for hypothyroidism, etc.

Good Drug Monitoring items should:
- be based on a clinical scenario in which a patient is starting to take a treatment and the candidate is being asked to identify the best way of monitoring its beneficial or adverse effects
- be based on a list of 5 monitoring options relating to the treatment identified, from which the candidate will be required to select the most appropriate
- avoid over-elaborate clinical scenarios, but contain sufficient information to allow a competent candidate to select the best option unambiguously
- contain 4 distracting options that, while plausible, are clearly less appropriate than the correct answer in relation to monitoring the beneficial or adverse effects of the treatment
- include a timescale within which the monitoring options should be judged (if appropriate).

Each of the items should follow the style:
‘Select the most appropriate option to monitor for [beneficial/adverse] effects of this prescription [after x hours/days/months etc.] of treatment. (mark it with a tick)’
Model Drug Monitoring Item

Case presentation
A 71-year-old woman is admitted to the respiratory ward with severe community-acquired pneumonia. She has been coughing up thick green sputum for 2 days.

On examination
Temperature 38.6°C, RR 20/min. Dullness to percussion and crackles at right lung base.

Investigations
CXR confirms right lower lobe pneumonia.
Treatment with co-amoxiclav (penicillin 1 g intramuscular and 200 mg). 1.2 g IV 8-hourly is initiated.

Question
Select the most appropriate option to monitor for beneficial effects of this prescription in the first 3 days of treatment. (Mark it with a tick)

<table>
<thead>
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<tr>
<td>A chest auscultation</td>
<td>☑</td>
</tr>
<tr>
<td>B chest X-ray</td>
<td>☑</td>
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<tr>
<td>C heart rate</td>
<td></td>
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<tr>
<td>D respiratory rate</td>
<td>☑</td>
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<tr>
<td>E review of sputum colour</td>
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Answers

Option A Justification
The auscultatory findings will take several days to resolve.

Option B Justification
The chest X-ray appearance is unlikely to resolve in the early stages of treatment.

Option C Justification
Heart rate is not a good indicator of treatment success.

Option D Justification
Successful treatment of the pneumonia will improve gas exchange and the hypoxia and reduce the respiratory rate.

Option E Justification
Sputum colour is a poor guide to the success of treatment for pneumonia.
Data Interpretation (DAT) items

The Data Interpretation section comprises six items, each of which requires identification of the most appropriate answer from a list of five. Each of the six items is worth 2 marks (making a total of 12 marks for this item style).

Reasoning and judgement required. Deciding on the meaning of the results of investigations as they relate to decisions about ongoing drug therapy.

Measurable action to be assessed. Making an appropriate change to a prescription based on those data.

Content. This item style involves interpreting data in the light of a clinical scenario and deciding on the most appropriate course of action with regard to prescribing. This may involve withdrawing a medicine, reducing its dose, no change, increasing its dose or prescribing a new medicine. The key focus of these items is interpreting the data and deciding on its implications for prescribing. Examples of data to be considered might include drug concentrations, haemoglobin concentration, white cell count, liver or renal function, serum cholesterol, nomograms, etc.

Good Data Interpretation items should:
• be based on a clinical scenario where a treatment decision (e.g. choosing from a selection of treatment options, deciding on a dosage change) relies upon interpreting data from an investigation (e.g. physiological measurement, blood test)
• be based on a list of 5 prescribing options relating to the treatment identified, from which the candidate will be required to select the most appropriate
• avoid over-elaborate clinical scenarios, but contain sufficient information to allow a competent candidate to select the best option unambiguously
• contain 4 distracting options that, while plausible, are clearly less appropriate than the correct answer in relation to responding to the data.

Each of the items should follow the style:
‘Select the most appropriate decision option with regard to the [insert drug name here] prescription/the treatment of [describe clinical condition here]] based on these data.
(mark it with a tick)’

Data Interpretation items must involve interpretation of a measured variable relevant to drug treatment. The challenge for the candidate is to use the measurement as a guide to changing the current prescription by adjusting the dosage of an existing medicine, withholding a medicine, or substituting an alternative.
### Model Data Interpretation item

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#### Case presentation:
A 70 year old man is admitted to hospital with orthostatic changes that have been increasing in frequency. PMS: Fall down following a brief loss of consciousness 2 weeks previously, he was discharged 4 weeks ago. (Hx) Medications: Sildenafil 50 mg PO daily, Simvastatin 40 mg PO daily, Docusate 100 mg PO daily. He has a history of diabetes mellitus. He will continue to take his medication daily.

#### Investigations:
- Serum potassium (3 weeks ago): 3.5 mmol/L.
- Serum sodium: 140 mmol/L.

#### Question:
Which is the most appropriate decision table with regard to the phenytoin sodium prescription based on these data?

- A: Discontinue phenytoin sodium
- B: Phenytoin sodium 200 mg PO daily
- C: Phenytoin sodium 200 mg PO daily
- D: Phenytoin sodium 200 mg PO daily
- E: Phenytoin sodium 100 mg PO daily

#### DECISION OPTIONS:

**Option A: Justification**

There is no reason to discontinue the phenytoin treatment.

**Option B: Justification**

The serum phenytoin concentration is sub-therapeutic, and will continue to fall unless the dose is increased.

**Option C: Justification**

Preparations containing phenytoin sodium are not bioequivalent to those containing phenytoin base (such as Benevir). The therapeutic effect is approximately equivalent to therapeutic effect of a 50% lower dose of phenytoin sodium. The serum concentration may be improved when switching from liquid tablets. Increasing the dose to 200 mg daily is appropriate.

**Option D: Justification**

A slow increase of 50% to 300 mg daily is likely to be too much, potentially resulting in toxicity.

**Option E: Justification**

A clear increase of 100% (300 mg daily) is likely to be too much, potentially resulting in toxicity.
Guidance on good item writing

Aims of the items
The PSA tests knowledge and skills related to the prescribing of medicines used in the treatment of common clinical conditions. It also tests the ability to process information set out in a clinical scenario and to use this to make a judgement about the safest and most effective treatment(s) to be prescribed. It aims to assess the competencies identified in Outcomes for graduates (2018) and by the Medical Schools Council Safe Prescribing Working Group (2007) including the ability to:

- write a safe and legal prescription
- appraise critically the prescribing of others
- plan appropriate therapy for common indications
- provide patients with appropriate information about their medicines
- calculate safe and appropriate medication doses
- monitor the efficacy and effects of medication
- detect and report adverse drug reactions.

Candidates are also expected to demonstrate knowledge of evidence-based medicine and nationally approved management guidelines related to common clinical presentations. These aims have led to the item styles and assessment structure outlined above.

Three of the 8 item styles aim to be close simulations of the relevant skills. Prescribing items necessitate writing a prescription into a template that includes a drug name, dose, route and frequency with appropriate timing and a signature. Prescription Review items require candidates to identify pre-existing prescriptions that require review and amendment. Calculation Skills items require an accurate calculation based on numerical data to choose a correct dose or timing for drug administration.

The other five item styles are based on identifying the single best answer (SBA) from a list of five possible answers. This format aims to simulate the challenge of making clinical decisions. In addition to testing knowledge and comprehension, it also allows for assessment of higher-level functions, such as application analysis, synthesis and evaluation. SBAs are superior to multiple true/false questions in their potential to assess the ability to interpret information and to solve clinical problems, as well as assessing core knowledge.

Structure of the items
Each item comprises three main components:

- *The stem.* A few lines/paragraphs of text explaining the clinical presentation upon which the item is based.
- *The lead-in.* A single line stating the requested action from the candidate.
- *The answer options.* Normally a list of five options (including one correct answer and four distractors). In the case of Prescribing items the answer will be written
into a form, for Prescription Review items the options are the current prescriptions taken by the patient, and for Calculation Skills items the answer will be a single numerical value.

Each of these components is discussed in detail below.

**The stem**
Clinical scenarios are conceived simply as the background to the prescribing-related knowledge or ability to be tested. The time available for candidates to read the stem is limited so the information it contains should be complete, concise, clear and unambiguous, omitting any extraneous details. Write the text of the stem in the present tense (‘A 78-year-old woman is admitted/presents with...’).

The stem must include:
- the age and gender of the patient (‘A 45-year-old man/woman’, ‘a 17-year-old boy/girl’)
- the setting of care, if relevant (e.g. outpatient clinic, emergency department)
- the patient’s domicile, race/ethnic origin or occupation, if relevant
- the presenting condition
- relevant medical, family and social history
- relevant drug treatment
- relevant physical examination findings, including the weight, where relevant
- results of relevant investigations (with reference ranges for comparison) in standard order.

Prescribing items test clinical judgement and will typically have stems that comprise text of 200–300 words divided into three paragraphs headed ‘**Case presentation**’, ‘**On examination**’ and ‘**Investigations**’ in bold.

The **Case presentation** paragraph will state the age and gender of the patient and outline the presenting condition, and may include past medical history, drug history and social history. These may be prefixed by the abbreviations **PMH.**, **DH.**, **FH.** and **SH**. in bold, which do not need to be defined. Details of the drug history should include the full regimen for each item. The following example shows the style preferred:

**DH.** Bendroflumethiazide 2.5 mg PO daily, simvastatin 20 mg PO nightly, amoxicillin 250 mg PO 8-hrly, metformin hydrochloride 1 g PO twice daily (as directed).

The **On examination** paragraph will contain a list of relevant examination findings that help to put the prescribing decision in context. Weight is obligatory for paediatric cases. The following example shows the style preferred:

**On examination**
Temperature 37.0°C, HR 94/min and rhythm regular, BP 116/76 mmHg, JVP 4 cm above sternal angle, RR 16/min, O₂ sat 94% breathing air. Apex beat in 6th left intercostal space, anterior axillary line, HS 1 + 2 + third sound at apex, bilateral
ankle oedema. Slightly short of breath at rest, inspiratory crackles at both lung bases. Abdomen soft, with hepatomegaly 4 cm below right costal margin. Neurological examination normal. Weight 78 kg. BMI 24 kg/m² (18–25).

The **Investigations** paragraph will contain a list of relevant investigations that support the prescribing decision in standard order (haematology–biochemistry–ECG–radiology–other investigations). Investigations will be presented with reference ranges. The following example shows the style preferred:

**Investigations**
- Hb 146 g/L (130–175), WCC 9.8 × 10⁹/L (3.0–10.0), platelets 190 × 10⁹/L (150–400).
- Na⁺ 140 mmol/L (137–144), K⁺ 4.2 mmol/L (3.5–4.9), U 7.2 mmol/L (2.5–7.0), Cr 85 µmol/L (60–110).
- ECG shows sinus tachycardia, LBBB. CXR shows consolidation in left lower zone.

Planning Management items will also follow the three-heading model above.

The stems for other items will normally be shorter (50–200 words) and may appear under a single heading of ‘**Case presentation**’, which may include any relevant examination findings and investigations if these are suitably brief.

Some items may be supported by an image (e.g. clinical photograph/X-ray/scan/ECG-monitoring chart). In all cases there should be an appropriate mix of text, investigations and images to allow a candidate to assimilate the information in about 2 minutes.

Please refer to **Appendix I** for a list of acceptable terms and abbreviations, to **Appendix II** for a table of reference ranges and thresholds for laboratory tests, and to **Appendix III** for British Approved Names of drugs. For further information about drug names and prescribing information refer to the *British National Formulary*.

Avoid use of unapproved abbreviations, jargon, or terms that may not be understood by candidates whose first language is not English. Use approved names for all medicines, avoid proprietary names unless these are recommended by the *British National Formulary*, and do not test knowledge of the use of medicines for unlicensed indications. Remember that some candidates will be dyslexic, so use simple and concise English. Further details on the creation of ‘dyslexia-friendly’ text can be obtained from the British Dyslexia Association (http://www.bdadyslexia.org.uk/common/ckeditor/filemanager/userfiles/About_Us/policies/Dyslexia_Style_Guide.pdf).

**The lead-in**
The lead-in should indicate clearly the basis on which any choice of options is to be made, how many options are to be selected and how to make those selections. The
lead in to Prescribing items will indicate clearly the purpose of the prescription to be written. The lead in for the Calculation Skills items will indicate the units in which the numerical answer should be given.

Lead-ins should avoid negatively worded questions, such as ‘What is the least likely diagnosis?’ or ‘What is the least appropriate treatment?’ Negatively worded questions are not only likely to be misread by candidates who are expecting to identify the most correct answer but present an artificial challenge that has no equivalent in everyday clinical practice.

The lead-in to all items will generally be consistent with the following templates and will appear in a highlighted box clearly separated from the stem:

Prescribing – ‘Write a prescription for ONE drug that is most appropriate to [treat/alleviate/prevent] [symptom or problem].
(use the [‘once only medicines’/’regular medicines’/’hospital IV fluid’/’general practice’) prescription form provided’

Prescription Review – ‘Select the [ONE/TWO/THREE prescription(s)] that [is/are] most likely to [be a cause of/contain a serious dosing error/interact/be contra-indicated, etc.].
(mark it/them] with a tick in column [A/B])’

Planning Management – ‘Select the most appropriate management option at this stage.
(mark it with a tick)’

Providing Information – ‘Select the most important information option that should be provided for the [patient/mother/staff nurse/GP].
(mark it with a tick)’

Calculation Skills – ‘What [dose/volume/duration/rate etc.] [(mL)/(mg)/(mL/h)/(tablets) etc.] of [name of the medicine] [should the patient take/is required etc.] [per dose/each day etc.] . . .
(write your answer in the box provided)’

Adverse Drug Reactions – Type A – ‘Select the adverse effect that is most likely to be caused by this treatment.
(mark it with a tick)’

Adverse Drug Reactions – Type B – ‘Select the prescription that is most likely to be contributing to the [insert adverse effect].
(mark it with a tick)’

Adverse Drug Reactions – Type C – ‘Select the prescription that is most likely to interact with [the drug specified in the stem] to [describe the clinical problem here].
(mark it with a tick)’

Adverse Drug Reactions – Type D – ‘Select the most appropriate option for the management of this adverse drug reaction.
(mark it with a tick)’
Drug Monitoring – ‘Select the most appropriate option to monitor for the [beneficial/adverse] effects of this prescription [after x hours/days/months etc.] of treatment. (mark it with a tick)’

Data Interpretation – ‘Select the most appropriate decision option with regard to the [(insert drug name here) prescription/the treatment of (describe clinical condition here)] based on these data. (mark it with a tick)’

**The five options**
The Prescribing and Calculation skills items require the candidate to enter the answer into a blank form. For Prescription Review items the options are the pre-existing prescriptions related to the case scenario. For all other items there will be five options that contain one correct answer to the lead-in question and four distractors.

Make sure that all the options are:
- relevant to the stem and follow logically from it
- supported by information in the stem, so that candidates can anticipate their appearance
- related to the lead-in
- balanced in length and content, and not overcomplicated.

The first word of each option should begin with a lower case letter, unless this word is a proper noun or the proprietary name of a medicine. The answer options will be automatically sorted into alphabetical order by the on-line authoring software (any that start with a number or Greek character will be placed first) and labelled A to E. The four distractors should be both plausible and realistic; answers that are clearly wrong lessen the question’s ability to discriminate among candidates. Authors should indicate the correct answer in the item template by selecting it with a tick.

To minimise the challenge presented by having to read through 60 questions, the style and format of each item are standardised as far as possible. A guide to the preferred style is presented in **House style** below.

**Resources**
Resources, such as images, may be used to complement items in the PSA. Use resources only if their interpretation helps candidates to reach the correct answer, and avoid using images that render the stem redundant because image identification leads directly to the correct answer. For information about use of resources and issues of consent see **Appendix VI**.

**Constructing good quality multiple choice questions**
The approach that leads most reliably to a good quality question uses the following process:
1. Identify the topic within which you wish to test cognitive ability and decide whether you wish to test recall of factual knowledge, synthesis (the ability to interpret information and integrate it to reach a conclusion), or judgement (the ability to choose a course of action taking into account the advantages and disadvantages of the alternatives).

2. Identify the precise point you wish to test. This helps to ensure that the topic is important, and that the level of knowledge is appropriate to the candidates likely to sit the PSA. Examples of unexpected ignorance, misconceptions or errors of judgement that have become apparent when teaching students usually offer the most fruitful ideas for testing-points.

3. Identify alternatives to the correct answer, which will act as plausible distractors. Make sure that these are indisputably less correct than the correct answer.

4. Build the stem as a fictional scenario that includes all the information necessary to select the correct answer (and no more). You may find that, having identified five possible answers to the lead-in, up to five different scenarios can be written, each one resulting in a different correct answer. Alternatively, while building the stem, you may perceive additional testing points that form the basis for further questions.

5. Check that the stem is written as economically as possible, and that the lead-in and the alternative answers follow logically from it.

6. Provide feedback for each answer option that helps to support the QA process and would help a candidate who wished to understand why their answer was incorrect.

7. Check that the style of the item conforms to that preferred by the PSA (see House style and Model items).

8. Apply appropriate metadata tagging to the item including author name, writing date, item style, diagnosis, clinical setting and principle categories of medicines.

Common pitfalls

- Information presented out of order (e.g. elements of past history in first line of stem, examination findings/investigations with presenting condition, symptoms interspersed with/following examination findings)
- Excessive detail in stem about the setting of care, medical/family/social history, examination findings or investigations
- Abbreviations contrary to house style
- Investigations listed in order different from that used in Table of Normal Values, containing incorrect units or lacking reference ranges
- Options in Providing Information items using language/terminology that would be inappropriate for the intended recipient
- Options listing drugs that the patient is taking for which no indication is given in the stem
• Calculation skills items resulting in doses that can’t be accurately measured or administered, and/or where variations in arithmetical rounding may result in more than one acceptable answer
• Calculation skills items involving reconstitution that omit to take the displacement value of the active substance into account
• Data Interpretation items containing no data, or data irrelevant for selection of correct prescription option

Summary points
In summary, remember to:
• avoid over-elaborate case presentations that contain excessive amounts of information
• ensure that clinical scenarios are relevant to the work of a Foundation doctor and demand only knowledge, skills and judgement that might be expected of that grade
• avoid asking questions that assess knowledge of trivial facts
• avoid asking questions that try to trick candidates by deliberately misleading them
• avoid lists of options that are unnecessarily complicated
• avoid making the preferred option significantly longer than the others
• avoid use of double options unless all five alternatives comprise double options
• avoid including options with common characteristics, where distractors are conceived simply as permutations of the correct answer and tend to converge
• avoid presenting information for the first time in the list of options; check that each option is supported by sufficient information in the stem to allow the candidate to anticipate its appearance
• when providing options relating to a choice of medicines, make sure that the information provided about each one is consistent
• make sure that numeric data are stated consistently
• avoid including words or terms in the stem that disclose the correct answer
Bibliography


House style

The following recommendations are conventions that the top publishers prefer, and which we have adopted as house style (with a few exceptions as noted).

Abbreviations
Avoid abbreviations in the stem wherever possible by spelling out the full words, at least the first time they appear in a single item. Exceptions include common abbreviations related to the clinical history, medicine administration routes and frequencies, examination and investigations. A full list of these accepted abbreviations, which do not require definition, is provided in Appendix I.

For all items: Use the abbreviated forms of medicine administration routes and frequencies (as listed in Appendix I) in the case presentation.
For MAN, COM, ADR, TDM and DAT items, use the abbreviated forms of medicine administration routes and frequencies (as listed in Appendix I) in the options list.
For REV items use the full description of medicine administration routes and frequencies (including the abbreviation in parentheses) in the list of current prescriptions. These should be selected from the drop-down lists provided.

Abbreviations of more than one capital letter take no full stops (e.g. CT, MCV, not C.T., M.C.V.)

Units of time will be written in full when they appear in the stem (years, weeks, hours, minutes) but most will be abbreviated when they appear in the investigations or in the answers (h, min, s). The exception will be when the time of day is used in the stem: this will be written using the 24-h clock notation (i.e. 09.00 h).

When expressing measurements, the following technical abbreviations are preferred:
HbA1c, kPa, PₐCO₂, PₐO₂ (or, if already clear that these are results of arterial blood gases, PCO₂, PO₂), SaO₂.

Transfer factor and transfer coefficient will be written out in full, at the least on the first occasion that they appear.

The choice of ‘a’ and ‘an’ before an abbreviation depends on pronunciation, not spelling. Thus, write ‘a CT scan’, but ‘an MRI scan’.

Font
The on-line authoring system at https://beta.admin.prescribingsafetyassessment.ac.uk/ automatically formats the text to the desired style. The default font is Calibri 12-point. This can be emboldened, italicised, underlined and altered to super/subscript where required (for example for scientific terms (e.g. HbA₁c and ¹⁴C-labelled)).
**Grammar and spelling**

The following are examples of preference and rules concerning words or expressions to be used in PSA items.

Avoid the terms ‘known’, ‘known to be’ and ‘known to have’ in relation to a diagnosis; thus, it is preferable to write ‘A 48-year-old man with hypertension’ rather than ‘A 48-year-old man with known hypertension’.

Capitalise the first letter of proper names (e.g. Gram positive) and the generic names of bacteria (when referring to both the genus and the species), but use lower case for all other nouns, including hospital departments (e.g. emergency department, intensive care unit, outpatient clinic), clinicians (e.g. cardiologist) and disorders (e.g. type 2 diabetes).

Write:

- ‘A 30-year-old man/woman’, not ‘male/female’
- ‘He was found to have type 2 diabetes’, not ‘he was diagnosed with type 2 diabetes’
- ‘The outpatient clinic’, not ‘outpatients’
- ‘Breathlessness of sudden onset’, not ‘sudden onset breathlessness’
- ‘DH. Warfarin 3 mg PO daily’, not ‘she was taking warfarin’
- ‘He was advised to take’, or ‘His GP prescribed a course of x’ not ‘he was prescribed’
- ‘He was treated with’, not ‘he received’ or ‘he was started on’
- ‘She underwent dialysis’, not ‘she had dialysis’ or ‘she was dialysed’.

Prefer ‘because of’ to ‘due to’, ‘before’ to ‘prior to’, ‘comprised’ to ‘consisted of’, ‘started’ to ‘commenced’, ‘concentration’ (of a substance in blood/urine) to ‘level’, ‘concentration’ (of a drug or compound in solution) to ‘strength’, ‘orientated’ to ‘oriented’, and ‘vasodilatation’ to ‘vasodilation’.

Use digraphs if their Latin or Greek roots support them. Thus, write anaemia, caecum and faecal, diarrhoea and oesophagus, but leucopenia, thrombocytopenia and osteopenia, and fetal, never foetal. Write oestradiol when referring to the hormone, but estradiol when referring to the drug.

Prefer -ise to -ize. Whereas -ize is used without exception by American writers and publishers, and is championed in the United Kingdom by Oxford University Press, most other publishers (and writers) in the UK favour -ise. Thus, write generalised and luteinising hormone.

Resist the tendency to create verbs from nouns. Thus, ‘the patient was endoscoped and lasered’ should read ‘the patient underwent endoscopy and laser treatment’.
Examination findings and investigations
Present the examination findings in the following order:
1. temperature
2. pulse (HR)
3. blood pressure (BP)
4. jugular venous pressure (JVP)
5. respiratory rate (RR)

Urinalysis results should be placed at the end of the examination paragraph, not in the list of investigations, using the form ‘Urinalysis showed blood 1+, protein 2+, leucocytes trace, nitrites nil.’
Write ‘mini-mental state examination’ and ‘Glasgow coma score’.

List relevant investigations in the standard order haematology-biochemistry-ECG-radiology-other investigations.

The term ‘X-ray’ (not x-ray, x ray or X-Ray), although not strictly correct, is widely understood and need not be replaced by ‘radiograph’. Refer to ‘CT (or MR) scan’. Thus, write:

- ‘CT scan head’
- ‘MRI scan brain’
- ‘US abdomen’
- ‘isotope bone scan’
- ‘ventilation/perfusion isotope lung scan’.

When referring to imaging investigations in the list of investigations, refer to echocardiogram (the visible record) rather than echocardiography (the investigation). Similarly, refer to MR angiogram, electroencephalogram, etc. However, when referring to imaging investigations in the list of options, refer to echocardiography (the investigation) not echocardiogram (the visible record). Similarly, refer to angiography, electroencephalography, endoscopic retrograde cholangiopancreatography, etc.
Grand Exemplars

The image below illustrates the preferred layout of the case presentation, on examination and investigations sections of a question. No single question would contain this much detail, but the ordering, and formatting and other conventions in this illustration may be used as an exemplar of how to present the relevant details.

Grand Exemplar – case presentation, on examination and investigations sections

**Case presentation**

A [age]-year-old [man/woman/child] presents to [location and situation] with [symptom] etc. PMH. Disease 1, disease 2, disease 3 ... [describe any past medical history relevant to the scenario]. DH. Generic name (brand name if required) 5 mg PO daily, drug 20 mg PO 8-hrly, drug 1 g PO as required ... [list any current prescriptions]. FH. Father died of asthma. SH. [include any relevant social history].

**On examination**

General observations. Temperature 37.0°C, HR 94/min and rhythm regular, BP 116/76 mmHg, JVP 4 cm above sternal angle, RR 16/min, O₂ sat 94% breathing air. Apex beat in 6th left intercostal space, anterior axillary line, HS 1 + 2 + third sound at apex, bilateral ankle oedema. Inspiratory crackles at both lung bases. PEFR 200 L/min (60% of expected). Abdomen soft, with hepatomegaly 4 cm below right costal margin. Neurological examination normal. Weight 76 kg.

**Investigations**

Hb 140 g/L (130–175/115–165), MCV 90 fl (80–96), WCC 6.0 × 10⁹/L (4.0–11.0), platelets 200 × 10⁹/L (150–400), PT 13 s (11.5–15.5), INR 1.0 (<1.4), ESR 40 mm/1h (<15/20/30). Na⁺ 140 mmol/L (137–144), K⁺ 4.2 mmol/L (3.5–4.9), U 7.2 mmol/L (2.5–7.0), Cr 85 µmol/L (60–110), eGFR 36 mL/min/1.73 m² (>60).

Alb 36 g/L (37–49), bill 34 µmol/L (1–22), ALT 30 U/L (5–35), alk phos 50 U/L (45–105), GGT 90 (<50/45–35), Hba₁c 5.0 % (4.0–6.0). CRP 5 mg/L (<10).

ECG shows sinus tachycardia, left bundle branch block. CXR shows consolidation in left lower zone (see image). US abdomen shows fatty liver.

CT brain shows left temporal subdural haematoma.

*Authors should provide sufficient information from the clinical examination and investigations to enable the candidate to make a sound judgement about the need for and choice of treatment.*

The image below shows the preferred layout of the current prescription section of REV items, illustrating the correct descriptions for medicines (including combination preparations, those requiring trade names, and non-solid dose forms). The expressions of dose, route and frequencies should be selected from the drop-down lists provided.

Grand exemplar - current prescription in REV items

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>bisoprolol fumarate</td>
<td>200 micrograms</td>
<td>Inhal HN</td>
<td>twice daily (12-hrly)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>co-amoxiclav 650/150 (amoxicillin 650 mg, clavulanate 150 mg) tablets</td>
<td>1 tablet</td>
<td>oral (PO)</td>
<td>three times daily (8-hrly)</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>ethinyl estradiol 30 micrograms/yosethisterone 150 micrograms monohydrate 21-day tablets</td>
<td>1 tablet</td>
<td>oral (PO)</td>
<td>daily</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>gentamicin 0.3% ear drops</td>
<td>1 drop</td>
<td>to left ear</td>
<td>three times daily (as directed)</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>haloperidol decanoate</td>
<td>50 mg</td>
<td>Intramuscular (IM)</td>
<td>every 4 weeks</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>hydrocortisone 1% cream</td>
<td>1 application</td>
<td>topical (TOP)</td>
<td>daily</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>insulin detemir 180 units/ml (Lantus&lt;sup&gt;®&lt;/sup&gt;)</td>
<td>10 units</td>
<td>Subcutaneous (SC)</td>
<td>twice daily (as directed)</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>levetiracetam monohydrate 500 mg tablets</td>
<td>50 mg</td>
<td>oral (PO)</td>
<td>twice daily (as directed)</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>nicotine lozenges</td>
<td>1 mg</td>
<td>Transmucosal</td>
<td>as required</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>theophylline 500 mg tablets (Nasal SABA)</td>
<td>200 mg</td>
<td>oral (PO)</td>
<td>twice daily (12-hrly)</td>
<td>✗</td>
<td>✓</td>
</tr>
</tbody>
</table>
Nomenclature

**Bacteria and viruses**

Although it is conventional for the Latinised names of bacteria in binary combination (stating both genus and species) to be italicised (e.g. *Streptococcus faecalis*, *Chlamydia* spp.), **we do not follow this convention** as italic script can be challenging for dyslexic candidates. Nevertheless, where the name of a bacterium appears in binary combination, the generic name should begin with a capital letter, with the specific name all in lower case. Anglicised versions of these names used in a general sense should appear in lower-case roman (e.g. staphylococcal infection, legionella pneumonia). Viruses are known by their subfamily names (herpes simplex virus, enterovirus), which are never italicised.

**Genetic terms**

Denote genes and chromosomes by letters and numbers. Whereas the names of bacterial and bacteriophage genes are italicised, genes from higher animals are usually referred to using roman letters (e.g. tRNA genes). Oncogenes are denoted as: c-myc, c-ras etc. Plasmid names are roman and start with a lower-case p. Endonucleases should take the form EcoRI, Sau3A etc. Denote chromosomes by roman capitals (e.g. X and Y). Generations are referred to also by lettered symbols in roman capitals: the parental (P), the first generation (F1), the second generation (F2) and so on.

**Medicines**

Use British Approved Name for medicinal substances. Refer to [Appendix III: Table of BANs](#) for list of BANs amended to conform with the Recommended International Non-proprietary Names (rINN)). All non-proprietary names of medicines are lower case. Include the salt name of a medicine if it is provided in the BNF index.

For the small number of medicines that should be prescribed by a proprietary or trade name (normally because of pharmacokinetic variations between products) this should be identified by including the trade name in parentheses that follow the generic pharmacological component(s) and their strength. Proprietary names will begin with a capital letter and retain a registration or trademark symbol where appropriate. For example, write ‘ciclosporin 25 mg (Neoral®) PO daily’.

Write ‘glucose 5%’, not ‘dextrose 5%’, and ‘sodium chloride 0.9%’ not ‘normal saline’. Write ‘β-adrenoceptor blocker’, not ‘β-blocker’ or ‘beta-blocker’. When referring to a medicine in an item stem, make clear why it is being taken/given and include the dose, and the route and frequency of administration.

Other conventions in connection with medicines include the following:

- a ‘dose’ is the amount of a medicine administered at a single point in time, whereas ‘dosage’ refers to the number and frequency of doses administered over a specific period of time
- refer to a drug ‘concentration’, not a drug ‘level’
• use the term ‘regimen’ rather than ‘regime’ when referring to a prescribed medicine or a standard combination of medicines used to treat a specific condition
• use the term ‘adverse effect’ rather than ‘unwanted effect’ or ‘side-effect.’

Numbers
As a rule, numbers from one to nine should be in words, with 10 and over in figures, unless this threshold is embraced (e.g. 9 or 10 items, not nine or 10 items). There are three exceptions:
• a number at the beginning of a sentence should always be spelt out
• in text, use arabic numerals when describing age (except for ‘thirties’, ‘forties’, etc.), names of conditions (e.g. type 2 diabetes), symbols, all abbreviated forms of units, and all units of time (minutes, hours, days, weeks, months, years)
• when stating medicine dosages, use arabic numerals for the dose (e.g. carbamazepine 200 mg) but spell out the number of dosage units to be administered ‘one tablet’, ‘one inhalation’
• convert the dosing frequency (e.g. three times daily) to a dose interval (e.g. 8-hrly) for dosing at regular intervals. However, use the format ‘three times daily (as directed)’ for medicines that should be given at other intervals during the day (e.g. oral hypoglycaemics, long-acting nitrates). Do not use abbreviations for Latin terms to signify dosing frequency (e.g. bd, tds, prn)

For numbers less than one, always precede the decimal point by a zero (e.g. 0.75). However, avoid decimal points for the doses of medicines; express doses smaller than 1 g in mg, and doses smaller than 1 mg (e.g. 0.5 mg) as micrograms (this should not be abbreviated, so write 500 micrograms, not 500 µg).

Always express temperature to one decimal place (e.g. 37.0°C, not 37°C) and ensure that all investigation results are expressed to the same number of decimal places as are used in their respective reference ranges.

Punctuation
Insert only a single letter space after all sentence punctuation, including full stops. Use a soft return (shift-enter) to move to a new line after section headings, but use hard returns (enter) to create a new paragraph, such as a new section of the case presentation.

Apostrophes
Write ‘an 8-month history’, and ‘3 months pregnant’, but ‘6 months’ duration’. Apostrophes are not used in toponymic designations (e.g. Ebola fever, Lyme disease), but still tend to be used for eponymic designations that derive from one person’s name (e.g. Alzheimer’s disease, Graves’ disease), despite the trend in North America towards using bare surnames. Eponymic designations that derive from two or more names do not carry an apostrophe (e.g. Creutzfeldt–Jakob disease), nor do commonly used abbreviations (e.g. flu).
**Commas**
The comma that is used to separate numbers in to units of three (e.g. 2,200) is dropped in technical and scientific work (2200) and replaced by a space for five-figure numbers and above (32 400, 3 240 000).

**En rules**
En rules are slightly longer than hyphens. Between names they distinguish between eponyms that are derived from the names of two people (e.g. Cheyne–Stokes) as opposed to those derived from the double-barrelled or unhyphenated name of one person (e.g. Brown-Séquard, Bence Jones). Thus, write Epstein–Barr virus, not Epstein-Barr or Epstein Barr.

En rules, not hyphens, are also used between words of equal importance whose order can be reversed without loss of meaning (e.g. dose–response, cost–benefit, tonic–clonic).

En rules are also used to indicate a range, without spaces before or after. Thus, write 76–96, not 76 – 96 or 76-96.

An en rule is also used to denote a minus sign.

To type an en rule, press Ctrl and the minus key on the numeric keyboard (using a PC), or Alt and the hyphen key (using a Mac). When using a PC laptop with no numeric keyboard, an en rule can be obtained from the Symbol menu.

**Hyphens**
Adjectives comprising prefixes are set as one word (e.g. antituberculous, postoperative), but use a hyphen for ease of reading where there is a risk of mispronunciation (e.g. un-ionised, nephro-urogram). Exceptions include nouns such as post mortem and amino acid.

Words beginning with ‘non’, indicating negation, are usually hyphenated (e.g. non-scaly, non-proliferative).

Use hyphens when referring to fractions (e.g. one-half, two-thirds) or compound numbers (e.g. twenty-four, thirty-six).

Compound modifiers that precede a noun are hyphenated (long-standing hypertension, first-degree heart block) but those that follow a noun are not. Do not hyphenate adjectival compounds beginning with adverbs ending in -ly (e.g. negatively worded questions).

Hyphenate ‘30 pack–year smoking history’ without a hyphen between the number and ‘pack’.

When writing the names of antibodies, use a hyphen where the name of the antibody includes an abbreviation (e.g. anti-Ro), or where the name includes more
than one word (e.g. anti-neutrophil cytoplasmic antibodies, anti-smooth muscle antibodies, anti-hepatitis C antibodies); do not use a hyphen where the antibody is a single word (e.g. anticentromere, antimitochondrial), unless there is a danger of mispronunciation.

**Plurals**
Abbreviations form the plural by adding -s, not -’s (e.g. ECGs). Abbreviated units of measurement usually take the same form in both singular and plural (e.g. mg, mL, h).

**Quotation marks**
British practice is to enclose quoted matter between single (not double) quotation marks, and this rule also applies to expressions that may be unfamiliar to some candidates (e.g. ‘well-woman clinic’). Double quotation marks should be used only for direct speech.

**Spacing**
Write <5 or –10 (not < 5 or – 10), 36.9°C (not 36.9 °C) and 20% (not 20 %), but otherwise leave a space between a numeral and any units (e.g. 25 mg, 120/70 mmHg), and either side of × and = signs.

**Symbols**
Abbreviate litre as ‘L’ (not ‘l’) and millilitre as ‘mL’ (not ‘ml’) and write µmol, (not umol), mmHg, cm, H₂O and × (from symbol menu), not x (e.g. 4.2 × 10⁹/L). The degree symbol in 37.0°C’ is also Symbol font, not a superscript letter ‘o’.

Isotopes should be written as a superscript number preceding the elemental abbreviation (e.g. ¹⁴C, ¹³¹I).

**Greek characters**
Use α, β, γ, etc. rather than alpha, beta, gamma, etc. For example, TNF-α, TNF-β, β-adrenoceptor blocker, β₂-agonist, etc. (Exceptions: gamma globulin, epoetin alfa, interferon beta, and other drug names.)

**Table style**
To insert a table, produce the table in a Word document, copy it and then use the ‘paste from Word’ button to insert the table into the item form. The following style is recommended for tables:

- Use lower case throughout, except for proper names, chemical symbols (such as PO₂, mmHg) (see Example 1 below)
- Headings for columns should be in bold. Headings for rows will be non-bold, unless other values are given and contrasted with normal values, when the word ‘normal’ should appear in bold (see Example 2 below)
- Column headings should follow the order of the Table of reference ranges and thresholds
- Align decimal points vertically.
Example 1.

<table>
<thead>
<tr>
<th></th>
<th>PO₂</th>
<th>PCO₂</th>
<th>pH</th>
<th>bicarbonate</th>
</tr>
</thead>
<tbody>
<tr>
<td>pre-treatment</td>
<td>12.1</td>
<td>5.6</td>
<td>8.1</td>
<td>45</td>
</tr>
<tr>
<td>post-treatment</td>
<td>11.5</td>
<td>4.8</td>
<td>7.4</td>
<td>21</td>
</tr>
</tbody>
</table>

Example 2.

<table>
<thead>
<tr>
<th></th>
<th>mean arterial pressure (mmHg)</th>
<th>mean right atrial pressure (mmHg)</th>
<th>mean pulmonary arterial pressure (mmHg)</th>
<th>mean pulmonary arterial wedge pressure (mmHg)</th>
<th>mean cardiac output (L/min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>normal</td>
<td>85</td>
<td>3</td>
<td>15</td>
<td>9</td>
<td>5.0</td>
</tr>
<tr>
<td>Day 1</td>
<td>80</td>
<td>8</td>
<td>22</td>
<td>20</td>
<td>3.0</td>
</tr>
<tr>
<td>Day 2</td>
<td>110</td>
<td>18</td>
<td>20</td>
<td>11</td>
<td>4.0</td>
</tr>
<tr>
<td>Day 3</td>
<td>85</td>
<td>6</td>
<td>16</td>
<td>8</td>
<td>2.5</td>
</tr>
<tr>
<td>Day 4</td>
<td>66</td>
<td>20</td>
<td>22</td>
<td>20</td>
<td>2.0</td>
</tr>
<tr>
<td>Day 5</td>
<td>75</td>
<td>2</td>
<td>12</td>
<td>8</td>
<td>3.5</td>
</tr>
</tbody>
</table>
PSA quality assurance process summary

The flow chart below shows the progress of item material through successive versions (V0-4) from first drafting through the stages of editing and quality assurance to the item bank, and onwards to consideration by the Assessment Board and Standard Setting Group for inclusion in an Assessment.

Peer Review Process

The PSA peer review meetings provide assurance that all PSA items that are entered into the item bank (and might be viewed by candidates) are fit for the intended purpose – to assess the prescribing-related competencies described in the blueprint. The meeting format allows a group of clinicians/pharmacists to look in detail at PSA items and assess them against an agreed set of review criteria according to a standardised process. Each event requires people, time, facilities and supporting information.

People

- Clinicians/pharmacists with an understanding of clinical pharmacology and of the prescribing activity required of Foundation doctors, who have attended a training workshop on writing items for the PSA.
- A chair with a detailed understanding of the PSA items and peer review processes. This individual will provide brief training and introduction to the process, will monitor the process and ensure that all of the steps are taken for each item being reviewed.
• Members who work in groups of 4–7. They review edited versions (V2) of the items that group members have written. The group come to a consensus about whether the item is appropriate for inclusion, subject to any modifications being made.
• Every alteration that is made to an item is recorded with a fully traceable version history. Whenever an item is edited, a brief explanation of the change that has been made should be entered in the update notes section. Any points that are intended to be considered and/or acted upon by the author, editor or assessment board should be made in the review notes section of the item.
• Peer review meetings take place annually, ensuring that questions about recent changes in practice are included within the item bank. Psychometric data pertaining to used items is used to review item performance. All items are reviewed periodically, using a rolling programme, to ensure that the bank remains up to date.

Time
• Peer review meetings will, as standard, take place over two days at a suitable venue, usually with an overnight stay.

Facilities
• Separate rooms to accommodate each group. Each group uses a computer, digital projector and screen/plasma screen for real-time editing.

Documents and other information
The following will be provided to participants:
• PSA Assessment Blueprint and Item Writing Manual
• Overview of the PSA peer review process
• A list of items to be peer reviewed in hard copy and on the PSA website
• Certificate of attendance for CPD accreditation
• Expenses claim forms
• Evaluation forms
Process
Where possible peer reviewers will consider items in the same style sequentially before moving on to another style. They will examine one item at a time, using the same standardised process. There are three main steps to the peer review process: initial review, detailed review, edit and decisions. These are described in detail below.

Initial review (focus: face validity)
Looking at the scenario and question only:
1) Are the scenario and question relevant to the prescribing duties of an F1 doctor?
2) Do the scenario and question elicit the reasoning and judgement required by the item type (ref. Blueprint)?
3) Do the scenario and question elicit the measurable action required by the item type (ref. Blueprint)?
For MCQ items only:
4) Consider the appropriate answer to the question. Reveal the answer option. Does the item pass the cover test? Is the answer option the correct answer?
For Prescribing items only:
5) Consider all the optimal and suboptimal but creditworthy answers to the question. Reveal optimal and sub-optimal answers. Is/are all the optimal and sub-optimal answers included appropriately?
For Calculation Skills items only:
6) Consider the appropriate answer to the question. Reveal the given answer. Is the answer the correct one?

Detailed review (focus: ambiguity and artificial bias)
Looking at the whole item including the correct answer and feedback provided on why this is the correct answer:
1) Do the scenario and question lead the candidate inappropriately to a correct or incorrect answer (i.e. bias)?
2) Are the scenario and question clear and unambiguous? Consider:
   - appropriate use of language
   - spelling and grammar
   - appropriate and accurate information
For SBA items only and looking at the answer options:
3) Is the correct answer too easy to identify from the list of options?
4) Is the correct answer too difficult to identify from the list of options?

Edit and decisions
1) Record whether the item is accepted or rejected.
   a. If accepted, convert the item status to V3.
   b. If rejected but retrievable, convert the status to VR (returned to author for further work).
   c. If rejected and not retrievable, delete the item (change status to DD)
2) Modify the item as agreed and record any changes made
3) Record brief justification of decisions made
Acknowledgements

Original Edition (July 2011) authored by Professor Simon Maxwell, Dr John Mucklow & Dr Lynne Bollington.

Revised Edition (August 2019) updated and reviewed by Professor Simon Maxwell (Medical Director, PSA) & Dr Lynne Bollington (Lead Consultant, PSA).

The authors of this manual are grateful to the Federation of Royal Colleges of Physicians of the United Kingdom for permission to reproduce and adapt the content of its Question-writing manual for the MRCP(UK) Examination for general guidance on question writing, and some content in Appendices II and IV.
APPENDIX I
Acceptable terms and abbreviations

Prescribing frequency and form terms (and abbreviations where permitted)
- as required
- once only
- daily
- nightly
- every 30 minutes
- every hour
2-hrly  every 2 hours (2-hrly)
3-hrly  every 3 hours (3-hrly)
4-hrly  six times daily (4-hrly)
- five times daily (as directed, before food, etc (as appropriate))
6-hrly  four times daily (6-hrly)
- four times daily (as directed, before food, etc (as appropriate))
8-hrly  three times daily (8-hrly)
- three times daily (as directed, before food, etc (as appropriate))
12-hrly twice daily (12-hrly)
- twice daily (as directed, before food, etc (as appropriate))
- every other day
- every 3 days
- every 4 days
- twice weekly
- three times weekly
- five times weekly
- weekly
- every 2 weeks
- every 4 weeks/monthly
- every 6 weeks
- every 8 weeks (2-monthly)
- every 12 weeks (3-monthly)
m/r    modified-release

Prescribing route terms (and abbreviations where permitted)
- buccal
INH   inhaled
- intradermal
IM    intramuscular
IV    intravenous
- intravitreal
- nasal
NEB   nebulised
PO    orally
- oromucosal
PR    rectal
SL    sublingual
SC    subcutaneous
- to both ears
- to left/right ear
- to both eyes
- to left/right eye
TOP topical
PV vaginal

Clinical history
PMH past medical history
DH drug history
FH family history
SH social history

Clinical diagnoses
AF atrial fibrillation
CKD (stage x) chronic kidney disease
COPD chronic obstructive pulmonary disease
DVT deep venous thrombosis
GORD gastro-oesophageal reflux disease
LBBB/RBBB left/right bundle branch block
UTI urinary tract infection
VF ventricular fibrillation

Clinical examination
BP blood pressure (mmHg)
HR heart rate (per minute)
HS heart sounds
JVP jugular venous pressure (centimetres)
RR respiratory rate (per minute)
O₂ sat peripheral oxygen saturation (SpO₂)
PEFR peak expiratory flow rate
FEV₁ forced expiratory volume in 1 second
FVC forced vital capacity
FiO₂ fraction of inspired oxygen
BMI body mass index

Other common abbreviations
BNF British National Formulary
ENT Ear, Nose and Throat
GP General practitioner
NHS National Health Service
NICE The National Institute for Health and Care Excellence
Investigations - Haematology
FBC  full blood count
Hb  haemoglobin
MCV  mean cell volume
WCC  white cell count
ESR  erythrocyte sedimentation rate
PT  prothrombin time
INR  international normalised ratio
aPTT  activated partial thromboplastin time

Investigations - Biochemistry
Na⁺  serum sodium
K⁺  serum potassium
Cl⁻  serum chloride
HCO₃⁻  serum bicarbonate
U  serum urea
Cr  serum creatinine
eGFR  estimated glomerular filtration rate
Ca²⁺ (corrected)  serum corrected calcium
Ca²⁺  serum ionised calcium
PO₄³⁻  serum phosphate
alb  serum albumin
bili  serum total bilirubin
ALT  serum alanine aminotransferase
AST  serum aspartate aminotransferase
alk phos  serum alkaline phosphatase
GGT  serum gammaglutamyltranspeptidase
HbA₁c  haemoglobin A¹c

Investigations – Immunology/Rheumatology
CRP  serum C-reactive protein
HIV  human immunodeficiency virus

Investigations - Others
AXR  abdominal X-ray
CSF  cerebrospinal fluid
CTPA  CT pulmonary angiogram
CXR  chest X-ray
DEXA  dual energy x-ray absorptiometry (scan)
US  ultrasound scan
CT  computerised tomography
MRI  magnetic resonance imaging (scan)
TSH  serum thyroid stimulating hormone

Units of measurement

g/L  grams per litre
mg/L  milligrams per litre
µg/L  micrograms per litre
mmol/L  millimoles per litre
µmol/L  micromoles per litre
## APPENDIX II

### Table of reference ranges and thresholds

Ranges appear in the order in which values should appear in lists of investigations. The name of the investigation should appear in full in each item, unless the abbreviated form is shown in parentheses beside it. The units appear before the ranges in parentheses for ease of copying and pasting from this document to items. Italicised words should not be reproduced in items. Paediatric variants of the most commonly reported values are given in dark grey. Reference ranges for less commonly reported paediatric values are available from the [Royal College of Paediatrics and Child Health](https://www.rcpch.ac.uk).

### Haematology

#### Haemoglobin (Hb)

<table>
<thead>
<tr>
<th></th>
<th>males</th>
<th>females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>g/L (130–175)</td>
<td>g/L (115–165)</td>
</tr>
<tr>
<td>infants and children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–6 days</td>
<td>g/L (145–220)</td>
<td></td>
</tr>
<tr>
<td>7 days</td>
<td>g/L (140–186)</td>
<td></td>
</tr>
<tr>
<td>8 days – 3 months</td>
<td>g/L (95–125)</td>
<td></td>
</tr>
<tr>
<td>3 months – 4 years</td>
<td>g/L (110–140)</td>
<td></td>
</tr>
<tr>
<td>5–12 years</td>
<td>g/L (115–140)</td>
<td></td>
</tr>
</tbody>
</table>

#### red cell count

<table>
<thead>
<tr>
<th></th>
<th>males</th>
<th>females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>× 10¹²/L (4.3–5.9)</td>
<td>× 10¹²/L (3.5–5.0)</td>
</tr>
<tr>
<td>infants and children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at birth (full term)</td>
<td>× 10¹²/L (3.7–6.5)</td>
<td></td>
</tr>
<tr>
<td>2 weeks</td>
<td>× 10¹²/L (3.9–5.9)</td>
<td></td>
</tr>
<tr>
<td>4 weeks</td>
<td>× 10¹²/L (3.1–4.3)</td>
<td></td>
</tr>
<tr>
<td>2–6 months</td>
<td>× 10¹²/L (3.9–5.5)</td>
<td></td>
</tr>
<tr>
<td>6 months – 1 year</td>
<td>× 10¹²/L (4.1–5.3)</td>
<td></td>
</tr>
<tr>
<td>1–6 years</td>
<td>× 10¹²/L (3.9–5.3)</td>
<td></td>
</tr>
<tr>
<td>6–12 years</td>
<td>× 10¹²/L (4.0–5.2)</td>
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</table>

#### haematocrit

<table>
<thead>
<tr>
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<th>males</th>
<th>females</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(0.40–0.52)</td>
<td>(0.36–0.47)</td>
</tr>
<tr>
<td>infants and children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at birth (full term)</td>
<td>(0.47–0.75)</td>
<td></td>
</tr>
<tr>
<td>2 weeks</td>
<td>(0.41–0.65)</td>
<td></td>
</tr>
<tr>
<td>4 weeks</td>
<td>(0.28–0.42)</td>
<td></td>
</tr>
<tr>
<td>2–6 months</td>
<td>(0.31–0.41)</td>
<td></td>
</tr>
<tr>
<td>6 months – 1 year</td>
<td>(0.33–0.41)</td>
<td></td>
</tr>
<tr>
<td>1–6 years</td>
<td>(0.34–0.40)</td>
<td></td>
</tr>
<tr>
<td>6–12 years</td>
<td>(0.34–0.45)</td>
<td></td>
</tr>
</tbody>
</table>
### mean cell volume (MCV)

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range (fL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 months</td>
<td>100–130</td>
</tr>
<tr>
<td>3–4 months</td>
<td>85–100</td>
</tr>
<tr>
<td>4 months – 4 years</td>
<td>70–86</td>
</tr>
<tr>
<td>4–12 years</td>
<td>77–91</td>
</tr>
</tbody>
</table>

**infants and children**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range (fL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 months</td>
<td>100–130</td>
</tr>
<tr>
<td>3–4 months</td>
<td>85–100</td>
</tr>
<tr>
<td>4 months – 4 years</td>
<td>70–86</td>
</tr>
<tr>
<td>4–12 years</td>
<td>77–91</td>
</tr>
</tbody>
</table>

### mean cell haemoglobin (MCH)

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range (pg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 months</td>
<td>31–37</td>
</tr>
<tr>
<td>3–4 months</td>
<td>27–33</td>
</tr>
<tr>
<td>4 months – 12 years</td>
<td>23–31</td>
</tr>
</tbody>
</table>

**infants and children**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range (pg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 months</td>
<td>31–37</td>
</tr>
<tr>
<td>3–4 months</td>
<td>27–33</td>
</tr>
<tr>
<td>4 months – 12 years</td>
<td>23–31</td>
</tr>
</tbody>
</table>

### mean cell haemoglobin concentration (MCHC)

**g/dL** (32–35)

### white cell count (WCC)

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–6 days</td>
<td>10.0–26.0</td>
</tr>
<tr>
<td>7 days</td>
<td>5.0–21.0</td>
</tr>
<tr>
<td>8 days – 6 months</td>
<td>6.0–15.0</td>
</tr>
<tr>
<td>7 months – 5 years</td>
<td>5.0–12.0</td>
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</tbody>
</table>

**infants and children**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2 days</td>
<td>2.0–4.5</td>
</tr>
<tr>
<td>3 days</td>
<td>1.5–9.0</td>
</tr>
<tr>
<td>4 days</td>
<td>1.5–10.0</td>
</tr>
<tr>
<td>5 days – 12 months</td>
<td>1.5–8.0</td>
</tr>
<tr>
<td>1–6 years</td>
<td>1.5–9.5</td>
</tr>
<tr>
<td>7–10 years</td>
<td>1.5–7.0</td>
</tr>
</tbody>
</table>

### neutrophils

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 days</td>
<td>5.0–13.0</td>
</tr>
<tr>
<td>4 days</td>
<td>1.5–10.0</td>
</tr>
<tr>
<td>5 days – 6 years</td>
<td>1.5–8.0</td>
</tr>
<tr>
<td>7–11 years</td>
<td>2.0–6.0</td>
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</tbody>
</table>

**infants and children**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 days</td>
<td>0.50–1.50</td>
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</tbody>
</table>

### lymphocytes

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2 days</td>
<td>2.0–4.5</td>
</tr>
<tr>
<td>3 days</td>
<td>3.0–9.0</td>
</tr>
<tr>
<td>4 days – 12 months</td>
<td>4.0–10.0</td>
</tr>
<tr>
<td>1–6 years</td>
<td>1.5–9.5</td>
</tr>
<tr>
<td>7–10 years</td>
<td>1.5–7.0</td>
</tr>
</tbody>
</table>

**infants and children**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 days</td>
<td>0.20–1.00</td>
</tr>
</tbody>
</table>

### monocytes

**adults**

<table>
<thead>
<tr>
<th>Infant and Child Age</th>
<th>Range ($\times 10^9$/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 days</td>
<td>0.50–1.50</td>
</tr>
</tbody>
</table>
**Prescribing Safety Assessment (PSA) Item Writing Manual**

*4 days – 6 years*  
\(\times 10^9/L\) (0.30–1.10)

*7–10 years*  
\(\times 10^9/L\) (0.20–1.20)

**Eosinophils**

*Adults*  
\(\times 10^9/L\) (0–0.40)

*Infants and children*  

*0–3 days*  
\(\times 10^9/L\) (0.10–2.00)

*4 days – 6 years*  
\(\times 10^9/L\) (0.10–1.00)

*7–10 years*  
\(\times 10^9/L\) (0.10–0.80)

**Basophils**  
\(\times 10^9/L\) (0–0.10)

**Platelets**  
\(\times 10^9/L\) (150–400)

**Reticulocytes**  
\(\times 10^9/L\) (25–85)

**Reticulocytes%**  
% (0.5–2.4)

**Erythrocyte sedimentation rate (ESR)**  
mm/h (<20)

**Plasma viscosity (25°C)**  
mPa/s (1.50–1.72)

**Coagulation screen**

**Prothrombin time (PT)**  
s (11.5–15.5)

**International normalised ratio (INR)**  
(<1.4)

*But, for patients taking warfarin (INR)*  
(target 2.5 (or 3.5))

**Activated partial thromboplastin time (aPTT)**  
s (30–40)

**Thrombin time**  
s (15–19)

**Fibrinogen**  
g/L (1.8–5.4)

**Bleeding time**  
min (3.0–8.0)

**Coagulation factors**

**Factors II, V, VII, VIII, IX, X, XI, XII**  
IU/dL (50–150)

**Von Willebrand factor antigen**  
IU/dL (45–150)

**Von Willebrand factor activity**  
IU/dL (50–150)

**Protein C**  
IU/dL (80–135)

**Protein S**  
IU/dL (80–120)

**Antithrombin**  
IU/dL (80–120)

**Activated protein C resistance**  
(2.12–4.00)

**Fibrin degradation products**  
mg/L (<100)

**D-dimer**  
mg/L (<0.5)

**Haematinics**

**Serum iron**  
µmol/L (12–30)

**Serum iron-binding capacity**  
µmol/L (45–75)

**Serum ferritin**  
µg/L (15–300)

**Serum transferrin**  
g/L (2.0–4.0)

**Serum vitamin B\textsubscript{12}**  
ng/L (160–760)

**Serum folate**  
µg/L (2.0–11.0)
red cell folate \(\mu g/L\) (160–640) 
serum haptoglobin \(g/L\) (0.13–1.63) 
zinc protoporphyrin:haemoglobin ratio \(\mu mol/mol\) haemoglobin (<70)

haemoglobinopathy screen:
  - haemoglobin A \(%\) (>95)
  - haemoglobin A\(_2\) \(%\) (2–3)
  - haemoglobin F \(%\) (<2)
  - haemoglobin S \(%\) (0)
transferrin saturation \(%\) (20–50)
methaemoglobin \(%\) (<1)
Chemistry

Blood

serum sodium (Na⁺) mmol/L (137–144)
serum potassium (K⁺) mmol/L (3.5–4.9)
serum chloride (Cl⁻) mmol/L (95–107)
serum bicarbonate (HCO₃⁻) mmol/L (20–28)
anion gap mmol/L (12–16)
serum urea (U)
  adults mmol/L (2.5–7.0)
    infants and children
      0–12 months mmol/L (0.8–5.5)
      1–16 years mmol/L (2.5–6.5)
serum creatinine (Cr)
  adults µmol/L (60–110)
    infants and children
      Neonate µmol/L (21–75)
      1 month – 4 years µmol/L (13–39)
      5–11 years µmol/L (29–53)
      12+ years µmol/L (40–90)
estimated glomerular filtration rate (eGFR) mL/min/1.73 m² (>60)
serum corrected calcium mmol/L (2.20–2.60)
serum ionised calcium (Ca²⁺) mmol/L (1.13–1.32)
serum phosphate (PO₄³⁻) mmol/L (0.8–1.4)
serum total protein g/L (61–76)
serum albumin (alb) g/L (37–49)
serum globulin g/L (24–27)
serum total bilirubin (bili) µmol/L (1–22)
serum conjugated bilirubin µmol/L (<3.4)
serum aspartate aminotransferase (AST) U/L (1–31)
serum alanine aminotransferase (ALT) U/L (5–35)
serum alkaline phosphatase (alk phos) U/L (45–105)
serum gamma glutamyl transferase/transpeptidase (GGT)
  males U/L (<50)
  females U/L (4–35)
serum lactate dehydrogenase U/L (10–250)
serum acid phosphatase U/L (2.6–6.2)
serum creatine kinase
  males U/L (24–195)
  females U/L (24–170)
serum creatine kinase MB fraction % (<5)
serum troponin I µg/L (<0.1)
serum troponin T µg/L (<0.01)
fasting plasma glucose mmol/L (3.0–6.0)
random (or ‘finger prick’) capillary glucose mmol/L (<11.1)
haemoglobin A₁c (HbA₁c) mmol/mol (20–42)
serum α₁-antitrypsin g/L (1.1–2.1)
<table>
<thead>
<tr>
<th>Test</th>
<th>Unit</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum copper</td>
<td>µmol/L</td>
<td>(12–26)</td>
</tr>
<tr>
<td>Serum caeruloplasmin</td>
<td>mg/L</td>
<td>(200–350)</td>
</tr>
<tr>
<td>Serum aluminium</td>
<td>µg/L</td>
<td>(&lt;10)</td>
</tr>
<tr>
<td>Blood lead</td>
<td>µmol/L</td>
<td>(&lt;0.5)</td>
</tr>
<tr>
<td>Serum magnesium</td>
<td>mmol/L</td>
<td>(0.75–1.05)</td>
</tr>
<tr>
<td>Serum zinc</td>
<td>µmol/L</td>
<td>(6–25)</td>
</tr>
<tr>
<td>Serum urate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>males</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>females</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma lactate</td>
<td>mmol/L</td>
<td>(0.23–0.46)</td>
</tr>
<tr>
<td>Plasma ammonia</td>
<td>mmol/L</td>
<td>(0.19–0.36)</td>
</tr>
<tr>
<td>Serum angiotensin-converting enzyme</td>
<td>U/L</td>
<td>(25–82)</td>
</tr>
<tr>
<td>Plasma fructosamine</td>
<td>µmol/L</td>
<td>(&lt;285)</td>
</tr>
<tr>
<td>Serum amylase</td>
<td>U/L</td>
<td>(60–180)</td>
</tr>
<tr>
<td>Serum osmolality</td>
<td>mosmol/kg</td>
<td>(278–300)</td>
</tr>
<tr>
<td>Serum osmolar gap</td>
<td>mosmol</td>
<td>(&lt;10)</td>
</tr>
<tr>
<td>Thiopurine methyltransferase</td>
<td>U/L</td>
<td>(&gt;25)</td>
</tr>
<tr>
<td>Random (or ‘finger-prick’) capillary ketones</td>
<td>mmol/L</td>
<td>(&lt;0.6)</td>
</tr>
<tr>
<td><strong>Urine</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glomerular filtration rate</td>
<td>mL/min</td>
<td>(70–140)</td>
</tr>
<tr>
<td>24-h urinary total protein</td>
<td>g</td>
<td>(&lt;0.2)</td>
</tr>
<tr>
<td>24-h urinary albumin</td>
<td>mg</td>
<td>(&lt;30)</td>
</tr>
<tr>
<td>24-h urinary creatinine</td>
<td>mmol</td>
<td>(9–18)</td>
</tr>
<tr>
<td>24-h urinary calcium</td>
<td>mmol</td>
<td>(2.5–7.5)</td>
</tr>
<tr>
<td>24-h urinary copper</td>
<td>µmol</td>
<td>(0.2–0.6)</td>
</tr>
<tr>
<td>24-h urinary urate</td>
<td>mmol</td>
<td>(&lt;3.6)</td>
</tr>
<tr>
<td>24-h urinary oxalate</td>
<td>mmol</td>
<td>(0.14–0.46)</td>
</tr>
<tr>
<td>24-h urinary urobilinogen</td>
<td>µmol</td>
<td>(1.7–5.9)</td>
</tr>
<tr>
<td>24-h urinary coproporphyrin</td>
<td>nmol</td>
<td>(&lt;300)</td>
</tr>
<tr>
<td>24-h urinary uroporphyrin</td>
<td>nmol</td>
<td>(6–24)</td>
</tr>
<tr>
<td>24-h urinary δ-aminolevulinate</td>
<td>µmol</td>
<td>(8–53)</td>
</tr>
<tr>
<td>24-h urinary 5-hydroxyindoleacetic acid</td>
<td>µmol</td>
<td>(10–47)</td>
</tr>
<tr>
<td>Urinary osmolality</td>
<td>mosmol/kg</td>
<td>(100–1000)</td>
</tr>
<tr>
<td>Urinary osmolality after dehydration</td>
<td>mosmol/kg</td>
<td>(&gt;750)</td>
</tr>
<tr>
<td>Urinary albumin:creatinine ratio</td>
<td>mg/mmol</td>
<td>(&lt;2.5)</td>
</tr>
<tr>
<td><strong>males</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>females</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary protein:creatinine ratio</td>
<td>mg/mmol</td>
<td>(&lt;3.5)</td>
</tr>
<tr>
<td>Urine microscopy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White cells</td>
<td>/µL</td>
<td>(&lt;10)</td>
</tr>
</tbody>
</table>
**Faeces**

- stool weight (non-fasting)  
  g (<200)
- 24-h faecal nitrogen  
  mmol (70–140)
- 24-h faecal urobinogen  
  µmol (50–500)
- 24-h faecal coproporphyrin  
  µmol (0.018–1.200)
- faecal coproporphyrin  
  nmol/g dry weight (0.46)
- 24-h faecal protoporphyrin  
  µmol (<4)
- faecal protoporphyrin  
  nmol/g dry weight (<220)
- faecal total porphyrin  
  ether soluble  
  nmol/g dry weight (10–200)
  ether insoluble  
  nmol/g dry weight (<24)
- 24-h faecal fat (on normal diet)  
  mmol (<20)
- osmolality  
  mosmol/kg (300)
- osmolar gap [300 – 2 × (faecal Na + K)]  
  mosmol/kg (<100)
- faecal calprotectin  
  µg/g (<50)
- faecal elastase  
  µg/g (>200)
- faecal α₁-antitrypsin  
  µg/g (<300)

**Lipids and lipoproteins**

- serum cholesterol  
  mmol/L (<5.2)
- serum LDL cholesterol  
  mmol/L (<3.36)
- serum HDL cholesterol  
  mmol/L (>1.55)
- fasting serum triglycerides  
  mmol/L (0.45–1.69)

**Arterial blood gases, breathing air**

- PO₂  
  kPa (11.3–12.6)
- PCO₂  
  kPa (4.7–6.0)
- pH  
  (7.35–7.45)
- H⁺  
  nmol/L (35–45)
- bicarbonate  
  mmol/L (21–29)
- base excess  
  mmol/L (±2)
- lactate  
  mmol/L (0.5–1.6)
- carboxyhaemoglobin:  
  non-smoker % (<2)
  smoker % (3–10)
- oxygen saturation (incl. target range if receiving O₂) % (target 94–98)
- methaemoglobin % (<1)
Endocrinology

**Adrenal steroids (blood)**

plasma renin activity  
(after 30 min supine) pmol/mL/h (1.1–2.7)  
(after 30 min upright) pmol/mL/h (3.0–4.3)

plasma aldosterone (normal diet)  
(after 30 min supine) pmol/L (135–400)  
(after 4 h upright) pmol/L (330–830)  
plasma aldosterone:renin ratio (<25)  
plasma angiotensin II pmol/L (5–35)

serum cortisol (09.00 h) nmol/L (200–700)  
serum cortisol (22.00 h) nmol/L (50–250)

overnight dexamethasone suppression test (after 1 mg dexamethasone):  
serum cortisol nmol/L (<50)

low-dose dexamethasone suppression test (2 mg/day for 48 h):  
serum cortisol nmol/L (<50)

high-dose dexamethasone suppression test (8 mg/day for 48 h):  
serum cortisol nmol/L (should suppress to <50% of day 0 value)

short tetracosactide (Synacthen®) test (250 micrograms):  
serum cortisol (30 min after tetracosactide) nmol/L (>550)

serum 11-deoxycortisol nmol/L (24–46)  
serum dehydroepiandrosterone (09.00 h) nmol/L (7–31)  
serum dehydroepiandrosterone sulphate
  **males** µmol/L (2–10)  
  **females** µmol/L (3–12)  
serum androstenedione
  **males** nmol/L (1.6–8.4)  
  **females** nmol/L (0.6–8.8)  
  **postmenopausal** nmol/L (0.9–6.8)
serum 17-hydroxyprogesterone
  **males** nmol/L (1–10)  
  **females** nmol/L (1–10)  
  **follicular** nmol/L (1–10)  
  **luteal** nmol/L (10–20)
serum oestradiol
  **males** pmol/L (<180)  
  **females**
### Prescribing Safety Assessment (PSA) Item Writing Manual

<table>
<thead>
<tr>
<th><strong>Postmenopausal</strong></th>
<th>pmol/L (&lt;100)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follicular</strong></td>
<td>pmol/L (200–400)</td>
</tr>
<tr>
<td><strong>Mid-cycle</strong></td>
<td>pmol/L (400–1200)</td>
</tr>
<tr>
<td><strong>Luteal</strong></td>
<td>pmol/L (400–1000)</td>
</tr>
</tbody>
</table>

**Serum progesterone**

- **Males**
  - Follicular: nmol/L (<10)
  - Luteal: nmol/L (>30)

- **Females**
  - Follicular: nmol/L (<10)
  - Luteal: nmol/L (>30)

**Serum testosterone**

- **Males**
  - Follicular: nmol/L (<10)
  - Luteal: nmol/L (>30)

- **Females**
  - Follicular: nmol/L (<10)
  - Luteal: nmol/L (>30)

**Serum dihydrotestosterone**

- **Males**
  - nmol/L (1.0–2.6)

- **Females**
  - nmol/L (0.3–9.3)

**Serum sex hormone binding protein**

- **Males**
  - nmol/L (10–62)

- **Females**
  - nmol/L (40–137)

### Adrenal steroids (urine)

- 24-h urinary aldosterone: nmol (14–53)
- 24-h urinary free cortisol: nmol (55–250)

### Pancreatic and gut hormones

**Oral glucose tolerance test (75 g)**

- **2-h plasma glucose**
  - mmol/L (<7.8)

- **Plasma gastrin**
  - pmol/L (<55)

- **Plasma or serum insulin**
  - Overnight fasting: pmol/L (<186)
  - After hypoglycaemia (plasma glucose <2.2 mmol/L):
    - pmol/L (<21)

- **Serum C-peptide**
  - pmol/L (180–360)

- **Plasma glucagon**
  - pmol/L (<50)

- **Plasma pancreatic polypeptide**
  - pmol/L (<300)

- **Plasma vasoactive intestinal polypeptide**
  - pmol/L (<30)

### Anterior pituitary hormones

**Plasma adrenocorticotropic hormone (09.00 h)**

- pmol/L (3.3–15.4)

**Plasma adrenocorticotropic hormone (22.00 h)**

- pmol/L (3.3–15.4)

**Plasma follicle-stimulating hormone**

- **Males**
  - U/L (1.0–7.0)

- **Females**
  - Follicular: U/L (2.5–10.0)
  - Midcycle: U/L (25–70)
luteal
postmenopausal

serum growth hormone

basal, fasting and between pulses  
2 h after glucose tolerance test (75 g)  

insulin-induced hypoglycaemia (blood glucose <2.2 mmol/L):

serum luteinising hormone

males  
females

plasma antidiuretic hormone

Thyroid hormones

Catecholamines (blood)
**Metanephrines (urine)**

- 24-h urinary metanephrine: µg (<2)
- 24-h urinary normetanephrine: µg (<3)

**Others**

- Plasma parathyroid hormone: pmol/L (0.9–5.4)
- Plasma calcitonin: pmol/L (<27)
- Serum cholecalciferol (vitamin D₃): nmol/L (60–105)
- Serum 25-OH-cholecalciferol: nmol/L (45–90)
- Serum 1,25-(OH)₂-cholecalciferol: pmol/L (43–149)
- Serum insulin-like growth factor 1: nmol/L
  - 13–20 y: (9.3–56.0)
  - 21–40 y: (7.5–37.3)
  - 41–60 y: (5.6–23.3)
  - >60 y: (3.3–23.3)
- Serum IGF1:IGF2 ratio: (<10)

**Immunology/Rheumatology**

- CD4 count: × 10⁶/L (430–1690)
- CD8 count: × 10⁶/L (150–1000)
- Serum complement C3: mg/dL (65–190)
- Serum complement C4: mg/dL (15–50)
- Total serum haemolytic complement activity: U/L (150–250)
- Serum C-reactive protein (CRP): mg/L (<10)
- Serum IgG: g/L (6.0–13.0)
- Serum IgA: g/L (0.8–3.0)
- Serum IgM: g/L (0.4–2.5)
- Serum IgE: kU/L (<120)
- Serum IgD: mg/L (20–120)
- Serum IgG4: g/L (0.08–1.30)
- Serum κ free light chains: mg/L (3.3–19.4)
- Serum λ free light chains: mg/L (5.7–26.3)
- Serum free light-chain ratio: (0.26–1.65)
- Serum β₂-microglobulin: mg/L (<3)
- Serum mast cell tryptase (1 h post-reaction): µg/L (2–14)
- Interferon-γ release assay for M. tuberculosis: (negative/positive)

**Autoantibodies**

- Anti-acetylcholine receptor antibodies: (negative at 1:10)
- Anti-adrenal antibodies: (negative at 1:40)
- Anticentromere antibodies: (negative at 1:40)
anticardiolipin antibodies:
   IgG \hspace{1cm} \text{U/mL (<10)}
   IgM \hspace{1cm} \text{U/mL (<10)}

anti-cyclic citrullinated peptide antibodies
anti-double-stranded DNA antibodies (ELISA) \hspace{1cm} \text{U/mL (<73)}
anti-glomerular basement membrane antibodies
anti-lactoferrin antibodies

anti-neutrophil cytoplasmic antibodies:
   c-ANCA \hspace{1cm} \text{U/mL (<10)}
   p-ANCA \hspace{1cm} \text{U/mL (<10)}
   PR3-ANCA \hspace{1cm} \text{U/mL (<10)}
   MPO-ANCA \hspace{1cm} \text{U/mL (<10)}

antinuclear antibodies \hspace{1cm} \text{(negative at 1:20)}
extractable nuclear antigen

gastric parietal cell antibodies \hspace{1cm} \text{(negative at 1:20)}
intrinsic factor antibodies \hspace{1cm} \text{(negative)}
interstitial cells of testis antibodies \hspace{1cm} \text{(negative at 1:10)}
anti-Jo-1 antibodies
anti-La antibodies
antimitochondrial antibodies \hspace{1cm} \text{(negative at 1:20)}
anti-RNP antibodies
anti-Scl-70 antibodies
anti-Ro antibodies
anti-skeletal muscle antibodies \hspace{1cm} \text{(negative at 1:60)}
anti-Sm antibodies

anti-smooth muscle antibodies \hspace{1cm} \text{(negative at 1:20)}
anti-thyroid colloid and microsomal antibodies \hspace{1cm} \text{(negative at 1:10)}
antigliadin antibodies \hspace{1cm} \text{IU/L (<10)}
antiendomyosial antibodies
antitissue transglutaminase antibodies:
   IgA \hspace{1cm} \text{U/mL (<15)}
   IgG \hspace{1cm} \text{U/mL (<5)}
rheumatoid factor \hspace{1cm} \text{kIU/L (<30)}
antistreptolysin titre \hspace{1cm} \text{IU/mL (<200)}

**Hepatitis virus serology**

**A:**
   anti-hepatitis A IgG antibody \hspace{1cm} \text{negative}
   anti-hepatitis A IgM antibody \hspace{1cm} \text{negative}

**B:**
   anti-hepatitis B core (anti-HBc) antibody \hspace{1cm} \text{negative}
   anti-hepatitis B surface (anti-HBs) antibody
   hepatitis B surface antigen (HBsAg) \hspace{1cm} \text{IU/mL (lower detection limit 10, equivalent to 50 copies/mL)}
   hepatitis B e antigen (HBeAg) \hspace{1cm} \text{IU/mL (lower detection limit 10, equivalent to 50 copies/mL)}
   HBV DNA (**viral load**) \hspace{1cm} \text{IU/mL (lower detection limit 250)}
HBV genotype

A–H

C: anti-hepatitis C antibody negative
HCV RNA (viral load) IU/mL (lower detection limit 15)
HCV genotype 1–6

D: anti-hepatitis D IgG antibody negative
anti-hepatitis D IgM antibody negative

E: anti-hepatitis E IgG antibody negative
anti-hepatitis E IgM antibody negative

Tumour markers

serum α-fetoprotein kU/L (<10)
serum carcinoembryonic antigen µg/L (<10)
serum neurone-specific enolase µg/L (<12)
serum prostate-specific antigen µg/L (<2)
  males under 40 µg/L (<4)
  males over 40
serum β-human chorionic gonadotropin U/L (<5)
serum CA 125 U/mL (<35)
serum CA 15-3 U/mL (<35)
serum CA 19-9 U/mL (<33)

Viral loads

cytomegalovirus viral load copies/mL (lower detection limit 400)
Epstein–Barr viral load copies/mL (lower detection limit 250)
hepatitis B viral load IU/mL (lower detection limit 250)
hepatitis C viral load IU/mL (lower detection limit 15)
HIV viral load copies/mL (lower detection limit 40)
human herpesvirus-6 viral load copies/mL (lower detection limit 50)
human herpesvirus-8 viral load copies/mL (lower detection limit 50)

Therapeutic drug concentrations

serum carbamazepine µmol/L (20–50)
blood ciclosporin nmol/L (100–150)
blood tacrolimus
  ≤12 months following transplant ng/mL (8–12)
  >12 months following transplant ng/mL (5–10)
serum digoxin (taken at least 6 h post-dose) nmol/L (1.0–2.0)
### Prescribing Safety Assessment (PSA) Item Writing Manual

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum gentamicin (multiple-dose regimen)</td>
<td>mg/L</td>
<td>(5–7)</td>
</tr>
<tr>
<td>Infective endocarditis (peak)</td>
<td>mg/L</td>
<td>(&lt;1)</td>
</tr>
<tr>
<td>Pre-dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1 h post-dose)</td>
<td>mg/L</td>
<td>(3–5)</td>
</tr>
<tr>
<td>Other indications (peak)</td>
<td>mg/L</td>
<td>(5–10)</td>
</tr>
<tr>
<td>Pre-dose</td>
<td>mg/L</td>
<td>(&lt;2)</td>
</tr>
<tr>
<td>Serum vancomycin (trough)</td>
<td>mg/L</td>
<td>(10–15)</td>
</tr>
<tr>
<td>Serum lithium</td>
<td>mmol/L</td>
<td>(0.4–1.0)</td>
</tr>
<tr>
<td>Serum phenobarbital</td>
<td>µmol/L</td>
<td>(65–172)</td>
</tr>
<tr>
<td>Serum phenytoin</td>
<td>µmol/L</td>
<td>(40–80)</td>
</tr>
<tr>
<td>Serum primidone</td>
<td>µmol/L</td>
<td>(23–55)</td>
</tr>
<tr>
<td>Plasma theophylline</td>
<td>mg/L</td>
<td>(10–20)</td>
</tr>
<tr>
<td>Plasma clozapine</td>
<td>mg/L</td>
<td>(0.35–0.50)</td>
</tr>
</tbody>
</table>

**Cerebrospinal fluid (CSF)**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening pressure</td>
<td>mmH₂O</td>
<td>(120–250)</td>
</tr>
<tr>
<td>Total protein</td>
<td>g/L</td>
<td>(0.15–0.45)</td>
</tr>
<tr>
<td>Albumin</td>
<td>g/L</td>
<td>(0.066–0.442)</td>
</tr>
<tr>
<td>Chloride</td>
<td>mmol/L</td>
<td>(116–122)</td>
</tr>
<tr>
<td>Glucose</td>
<td>mmol/L</td>
<td>(3.3–4.4)</td>
</tr>
<tr>
<td>Lactate</td>
<td>mmol/L</td>
<td>(1.0–2.0)</td>
</tr>
<tr>
<td>Cell count</td>
<td>/µL</td>
<td>(≤5)</td>
</tr>
<tr>
<td>White cell count</td>
<td>/µL</td>
<td>(≤5)</td>
</tr>
<tr>
<td>Red cell count</td>
<td>/µL</td>
<td>(0)</td>
</tr>
<tr>
<td>Lymphocyte count</td>
<td>/µL</td>
<td>(≤3.5)</td>
</tr>
<tr>
<td>Neutrophil count</td>
<td>/µL</td>
<td>(0)</td>
</tr>
<tr>
<td>IgG:albumin ratio</td>
<td></td>
<td>(≤0.26)</td>
</tr>
<tr>
<td>Ig index</td>
<td></td>
<td>(≤0.88)</td>
</tr>
</tbody>
</table>

**Synovial fluid**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>White cell count</td>
<td>/mL</td>
<td>(&lt;200)</td>
</tr>
</tbody>
</table>

**Pulmonary function**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer factor for CO (TLCO)</td>
<td>%</td>
<td>(80–120)</td>
</tr>
<tr>
<td>Transfer coefficient (KCO)</td>
<td>mmol/min/kPa</td>
<td>(100)</td>
</tr>
</tbody>
</table>

**Cardiac pressures**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unit</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean arterial pressure</td>
<td>mmHg</td>
<td>(96)</td>
</tr>
<tr>
<td>Mean right atrial pressure</td>
<td>mmHg</td>
<td>(3)</td>
</tr>
<tr>
<td>Mean pulmonary arterial pressure</td>
<td>mmHg</td>
<td>(15)</td>
</tr>
<tr>
<td>Mean pulmonary arterial wedge pressure</td>
<td>mmHg</td>
<td>(9)</td>
</tr>
</tbody>
</table>
mean cardiac output L/min (5)

**Hepatic venous pressures**

- portal venous pressure mmHg (4–8)
- hepatic venous pressure mmHg (2–4)
- hepatic venous pressure gradient mmHg (<5)

**ECG measurements**

- PR interval ms (120–200)
- QRS complex ms (40–120)
- corrected QT interval (QTc)
  - males ms (<440)
  - females ms (<460)
APPENDIX III

British Approved Names (BANs) of certain medicines
(altered to conform with Recommended International Non-proprietary Names)

<table>
<thead>
<tr>
<th>Former BAN</th>
<th>New BAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>acyclovir</td>
<td>aciclovir</td>
</tr>
<tr>
<td>adrenaline</td>
<td>adrenaline (epinephrine)</td>
</tr>
<tr>
<td>amethocaine</td>
<td>tetracaine</td>
</tr>
<tr>
<td>amoxycillin</td>
<td>amoxicillin</td>
</tr>
<tr>
<td>beclomethasone</td>
<td>beclomethasone dipropionate</td>
</tr>
<tr>
<td>bendrofluazide</td>
<td>bendroflumethiazide</td>
</tr>
<tr>
<td>benzhexol</td>
<td>trihexyphenidyl hydrochloride</td>
</tr>
<tr>
<td>busulphan</td>
<td>busulfan</td>
</tr>
<tr>
<td>cephalaxin</td>
<td>cefalexin</td>
</tr>
<tr>
<td>cephadrine</td>
<td>cefradine</td>
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<tr>
<td>chlormethiazole</td>
<td>clomethiazole</td>
</tr>
<tr>
<td>chlorphniramine</td>
<td>chlorphenamine maleate</td>
</tr>
<tr>
<td>chlorthalidone</td>
<td>chlortalidone</td>
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<tr>
<td>choledicalciferol</td>
<td>colecalciferol</td>
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<tr>
<td>cholestyramine</td>
<td>colestyramine</td>
</tr>
<tr>
<td>clomiphene</td>
<td>clomifene citrate</td>
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<tr>
<td>colistin sulphomethate sodium</td>
<td>colistimethate sodium</td>
</tr>
<tr>
<td>cyclosporin</td>
<td>ciclosporin</td>
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<tr>
<td>cysteamine</td>
<td>mercaptamine</td>
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<tr>
<td>dexamphetamine</td>
<td>dexamfetamine sulfate</td>
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<tr>
<td>dicyclomine</td>
<td>dicycloverine hydrochloride</td>
</tr>
<tr>
<td>dimethicone(s)</td>
<td>dimeticone</td>
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<tr>
<td>dimethyl sulphoxide</td>
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<tr>
<td>dothiepin</td>
<td>dosulepin hydrochloride</td>
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<td>eformoterol</td>
<td>formoterol fumarate</td>
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<td>flumethasone</td>
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<td>hydroxyurea</td>
<td>hydroxy carbamide</td>
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<td>lignocaine</td>
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<td>levomepromazine</td>
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<td>methylthioninium chloride</td>
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<tr>
<td>mitoxantrone</td>
<td>mitoxantrone</td>
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<tr>
<td>Drug Name</td>
<td>Drug Name</td>
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<tr>
<td>---------------------------</td>
<td>-------------------------------</td>
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<tr>
<td>nicoumalone</td>
<td>acenocoumarol</td>
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<td>noradrenaline</td>
<td>noradrenaline (norepinephrine)</td>
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<td>oestradiol</td>
<td>estradiol</td>
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<td>estriol</td>
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<td>phenobarbitone</td>
<td>phenobarbital</td>
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<tr>
<td>riboflavine</td>
<td>riboflavin</td>
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<tr>
<td>salcetonin</td>
<td>calcitonin (salmon)</td>
</tr>
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APPENDIX IV

Diagnostic classification (‘Diagnosis’)

Cardiology
- Congenital heart disease
- Pericardial disease
- Myocardial disease
- Valvular heart disease
- Dysrhythmias
- Coronary artery disease (ischaemia)
- Vascular disease
- Systemic hypertension
- Pulmonary hypertension
- Cardiology symptoms/signs

Dermatology
- Bullous conditions
- Bacterial skin infections
- Viral skin infections
- Rickettsial disease
- Fungal skin infections
- Non-infectious infiltrates
- Disorders of skin appendages
- Disorders of skin vasculature
- Pigmentation disorders
- Systemic disorders and the skin
- Tumours/naevi of skin
- Genetic disorders of skin
- Dermatology symptoms/signs

Endocrinology and metabolic medicine
- Hereditary endocrine conditions
- Pituitary
- Thyroid disease
- Parathyroid glands
- Adrenal gland disorders
- Diabetes mellitus
- Diabetes insipidus
- Carcinoid syndrome
- Menopause
- Ovarian disorders
- Testicular disorders
- Bone disease
- Growth disorders
- Nutrition
- Inborn errors carbohydrate metab
- Inborn errors of amino acid metab
- Lysosomal storage disorders
- Disorders of purine metabolism
- Porphyria
- Wilson’s disease
- Lipid disorders
- Electrolyte disorders
- Endocrine symptoms/signs

Gastroenterology
- GI haemorrhage
- Oesophageal disorders
- Stomach and duodenal disorders
- Small intestinal disorders
- Pancreatic disorders
- Inflammatory bowel disease
- Bowel ischaemia
- Colon and rectal disorders
- Liver disorders
- Biliary tree
- Mouth and salivary gland
- Peritonitis
- Gastroenterology symptoms/signs

Haematology
- Macrocytic anaemias
- Microcytic anaemias
- Disorders of iron metabolism
- Normocytic anaemia (non-haemolytic)
- Hereditary haemolytic anaemia
- Acquired haemolytic disorders
- Abnormal haemoglobins
- Methaemoglobinemia
- Porphyria
- Polycythaemia
- Platelet disorders
- Coagulation disorders
- Thrombophilia
- Non-malignant white cell disorders
- Splenic disorders
- Transfusion medicine
- Malignant haematology
- Stem cell transplantation
- Haematology symptoms/signs

Infectious diseases
- Bacterial infection
- Fungal
- Helminths
- Protozoal
- Rickettsial
- Mycoplasma
- Chlamydia
- Spirochaetes
- Viral
- Prion diseases
- Septicaemia
- Infectious diseases symptoms/signs

Neurology
- Cerebrovascular disease
- Coma and brain death
- Confusional states
- Degenerative diseases
- Movement disorders
- Dizziness
- Loss of consciousness
- Headache and facial pain
- Hydrocephalus
- CNS infections
- Myelopathy/radiculopathy
- Demyelinating disorders
- Myopathy
- Motor neurone disease
- Neuromuscular junction disorders
- Neuropathy
- Sleep disorders
- Tumours of CNS
- Paraneoplastic syndromes
- Benign intracranial hypertension
- Congenital/developmental disorders
- Neurology symptoms/signs
Oncology and palliative medicine
- Premalignant conditions
- Paraneoplastic syndromes
- Tumours
- Palliative care
- Oncology symptoms/signs

Ophthalmology
- Disorders of the eyelid
- Disorders of the lacrimal gland
- Disorders of the orbit
- Disorders of the conjunctiva
- Episcleral and scleral disorders
- Corneal disorders
- Disorders of the iris and ciliary body
- Disorder of anterior chamber of eye
- Disorders of the lens
- Choroidal/chorioretinal disorders
- Disorders of vitreous and retina
- Glaucoma
- Disorder optic nerve/visual fields
- Pupillary function abnormality
- Nystagmus
- Thyroid eye disease
- Ophthalmology symptoms/signs

Psychiatry
- Organic mental disorder
- Dementia
- Psychoactive substance misuse
- Psychotic disorder
- Mood disorder
- Neurotic disorder
- Stress and adjustment disorder
- Behavioural disorders
- Personality disorders
- Factitious disorder
- Learning disability
- Disorder of psychological development
- Childhood hyperkinetic syndrome
- Tic disorder
- Suicide and parasuicide
- Alcohol syndromes
- Psychiatry symptoms/signs

Nephrology
- Hereditary renal disease
- Glomerular disease
- Proteinuria
- Tubulo-interstitial nephritis
- Reflux nephropathy
- Renal calculus disease
- Obstructive uropathy
- Urinary tract infection
- Renovascular disease/ischaemia
- Hypertension
- Malignancy of urinary tract
- Acute renal failure
- Chronic renal failure
- Renal tubular disease
- Diabetes insipidus
- Electrolyte abnormalities
- Pregnancy and renal disease
- Renal pain
- Drug-induced renal disease
- Nephrology symptoms/signs

Respiratory medicine
- Genetic disorders of lung
- Hypersensitivity/allergy
- Hypoventilation
- Respiratory failure
- Infections of respiratory tract
- Pulmonary thromboembolism
- Pulmonary haemorrhage
- Primary pulmonary hypertension
- Interstitial lung disease
- Extrinsic allergic alveolitis
- Pulmonary eosinophilia
- Systemic disorders involving lung
- Toxicity/occupational lung disease
- Tumours of respiratory tract
- Acid–base balance
- Pneumothorax
- Lung transplant
- Respiratory symptoms/signs

Rheumatology
- Inflammatory joint disease
- Connective tissue diseases
- Crystal deposition disease
- Diseases of bone
- Osteoarthritis
- Soft tissue disorders
- Charcot joint
- Rheumatology symptoms/signs

Geriatric medicine
- Incontinence
- Falls in the elderly
- Geriatric medicine symptoms/signs

Overdose/Poisoning
- Overdose/Poisoning

Surgery
- Surgical pain
- Postoperative pain
- Fluid balance
- Prevention of surgical complications
- Other postoperative care
- Trauma

Obstetrics & Gynaecology
- Amenorrhoea
- Menorrhagia/uterine bleeding
- Contraception
- Fertility
- Abortion
- Pregnancy
- Childbirth
- Breastfeeding
- Menopause
APPENDIX V

Therapeutic classification (‘Drug’)

Gastrointestinal system
Cardiovascular system
Respiratory system
Central nervous system
Infections
Endocrine system
Obstetrics, gynaecology, and urinary tract disorders
Malignant disease and immunosuppression
Nutrition and blood
Musculoskeletal and joint diseases
Eye
Ear, nose and throat
Skin
Immunological products and vaccines
Anaesthesia
Toxicology
APPENDIX VI

Adding resources to PSA items

Documents, photographs and other images may be added to PSA items to provide further clinical context, using the ‘add resource’ button. In all cases, the resource must contain information that is **required** to answer the question. In order to ensure that resources are suitable for use, authors should bear the following points in mind:

- Written records such as prescription charts and patient monitoring forms should be transcribed onto a blank form to avoid revealing confidential information. The hard copy should then be scanned or photographed and uploaded.

- A fluid administration record is available to download from the PSA site. It can be completed as required, and then, using the ‘screen grab’ function, a jpeg file can be created. Further templates will be added to the PSA interface over time.

- Scanned copies of imaging investigations (e.g. ECGs, X-rays) should have all identifying data removed.

- A number of image banks are available on the internet, providing access to photographs, illustrations and other images that may be used free of charge for educational purposes. The author must acknowledge the source of the image by noting this in the ‘review notes’ section of the item. Examples of image banks that may be used include:
  - [http://library.med.utah.edu/heal/](http://library.med.utah.edu/heal/)
  - [http://phil.cdc.gov/phil/home.asp](http://phil.cdc.gov/phil/home.asp)
  - [http://www.danderm-pdv.is.kkh.dk/atlas/index.html](http://www.danderm-pdv.is.kkh.dk/atlas/index.html)

- Photographs of individual patients may be used, provided they are anonymised and appropriate consent has been obtained (see ‘**Obtaining consent for making visual recordings of patients to use in the PSA**’ below.

Use the ‘Add Resource’ button in the PSA author template to add resources to individual question items. Once the image has been uploaded, check the item to ensure that the resource is clearly legible when viewed on the screen. Acceptable file types are * .jpg, * .jpeg, * .png and * .gif
Obtaining consent for making visual recordings of patients to use in the PSA

PSA authors are responsible for ensuring that any visual recordings (e.g. photographs) of patients supplied to the PSA for use in assessments have been obtained in compliance with the guidance set out by the GMC ‘Making and using visual and audio recordings of patients (March 2013)’ available from [http://www.gmc-uk.org/guidance/ethical_guidance/making_audiovisual.asp](http://www.gmc-uk.org/guidance/ethical_guidance/making_audiovisual.asp).

A photograph obtained before 1997, either as part of the patient’s treatment or assessment, or for teaching purposes within a medical setting, may be used without consent provided it has been effectively anonymised so that the patient is no longer identifiable.

Consent is not required to use images taken from pathology slides, X-rays, laparoscopic images, images of internal organs or ultrasound images, provided that they are effectively anonymised by removal of any identifying marks.

With the exception of the above, all other visual recordings, including those taken as part of patient care, require written or verbal consent to be obtained.

A consent form is available for use with images (see Consent form for using images in the PSA) below and can be downloaded from the PSA interface. When images requiring consent are uploaded to the PSA interface, a copy of the relevant signed consent form must be sent to [enquiries.psa@prescribe.ac.uk](mailto:enquiries.psa@prescribe.ac.uk) with a note of the item number the image relates to.
MSC ASSESSMENT/BRITISH PHARMACOLOGICAL SOCIETY

Consent for using images in the
Prescribing Safety Assessment (PSA)

Patient’s name______________________________________________________________

Hospital Trust or
GP practice ________________________________________________________________

*Delete where inapplicable

I hereby give my consent to have photographs, video recordings or other images made of
*myself/my family member/my ward to be used by MSC Assessment and the British
Pharmacological Society for the purpose of the Prescribing Safety Assessment. I have been
assured by Dr_______________________________ that *my/his/her identity will be
protected when any such image is reproduced.

I understand and agree that the British Pharmacological Society of the UK may also use
these anonymised images as illustrations for its eLearning project Prescribe

Patient/Guardian/Legal representative   Signature:

Name:

Physician seeking consent   Signature:

Name:

Date:
APPENDIX VII

Metadata tagging of PSA items

Data types

All items will be tagged with the following information:

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<tr>
<td>Setting</td>
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<tr>
<td>Drug</td>
<td>see Appendix V (drop-down menu)</td>
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Item Performance

Psychometric data about the facility and discrimination of items used in assessments are added once to individual items once they are available.