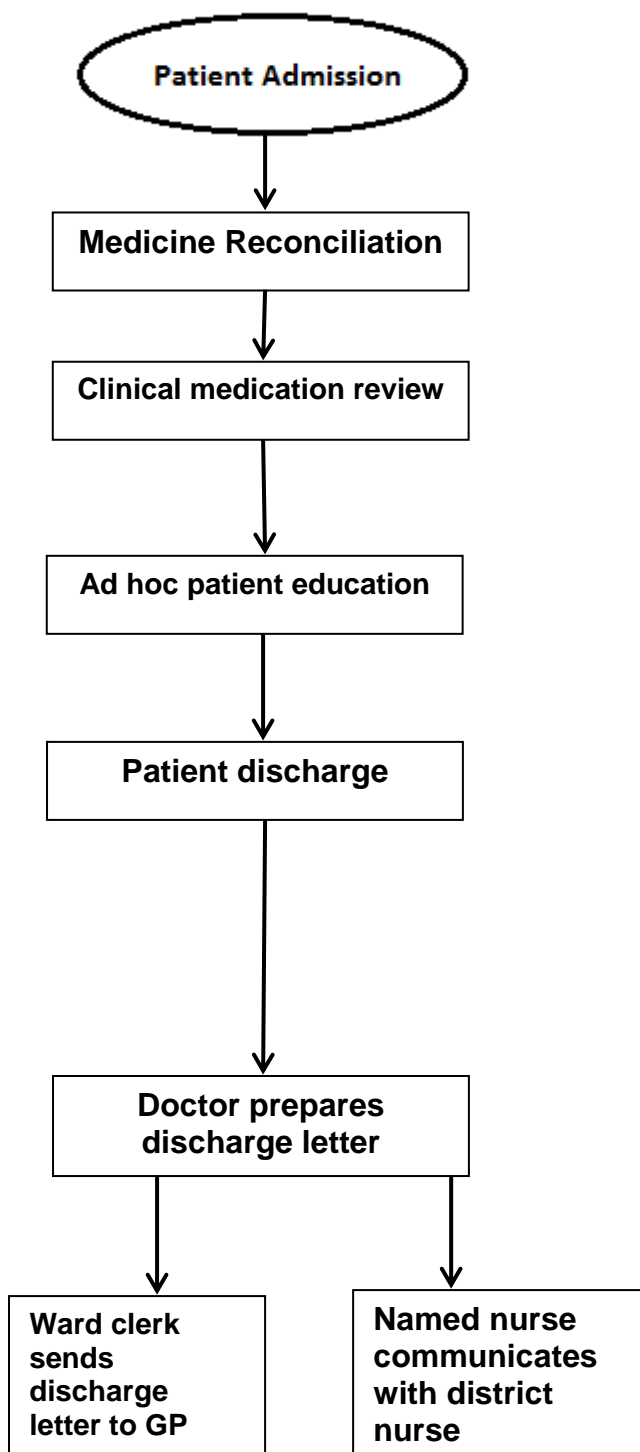
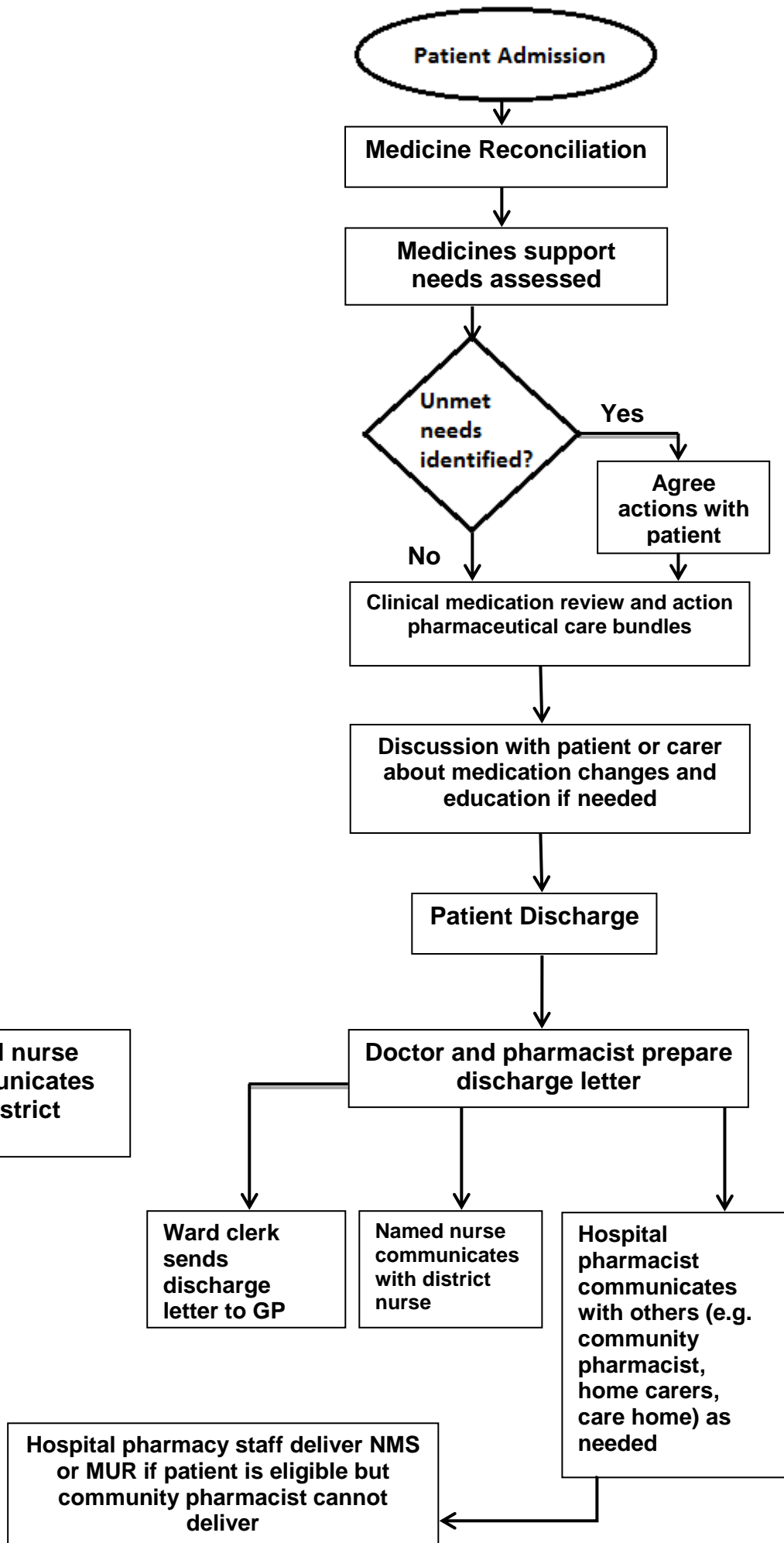


Control Ward



Intervention Ward



Medicines Support Needs Assessment

This form is to be used to assess the support required by a patient to aid medication adherence. It can also be used to determine if a reasonable adjustment is required from the pharmacist or prescriber under the Disability Discrimination Act (1995). The assessor will need to make a professional judgment on the type(s) of support needed after discussion with the patient to ensure the patient derives maximum benefit from their medication in line with their preferences and values.

File in discharge planning section of nursing notes once complete.

Affix patient identification label in box below or complete details

Surname	Patient i.d.No.
Forename	D.O.B. DDMMYYYY
Address	NHS No.
	Sex. Male / Female
Postcode	

GP	Usual Community Pharmacy
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Brief adherence and concordance assessment tool (BACAT)

Introduction: these questions are to help us find out whether you need more information or support with your medicines.

Use non-judgmental tone and language	Please circle patient response:	
1. Do you have difficulty getting the medicines from the doctor or pharmacy?	Yes	No
2. Do you have difficulty in opening the <i>packets</i> ..., swallowing the <i>tablets</i> ... or using the <i>cream</i> ... or <i>eye drops</i> ..?	Yes	No
3. Do you have difficulty reading the labels and instructions on your medicine packets?	Yes	No
4. Do you think you have missed or forgotten any doses in the week before you came into hospital?	Yes	No
5. Have you needed to take any extra doses of your medicines - more than your doctor prescribed?	Yes	No
6. Do you have any concerns about your medicines? Do your medicines give you side effects or upset you?	Yes	No
7. Could your medicines work better? Do you think you need something else?	Yes	No

Completed by (name) (signature) (date)

If patient answered yes to any question refer them to your clinical pharmacist. Referral made? Yes / No Date

Comprehensive assessment

(to be completed by a clinical pharmacist when problems are identified by using the screening tool above)

Current support (availability, limitations etc.)								
Family / friend					District nurse			
Home care					Other			
Complexity of current regimen								
	Morning	Midday	Evening	Night		No. prn meds	Any non-standard dose times?	Variable doses?
No. of regular doses							Y N	Y N
<p>Notes: Review medicines (any recognised criteria for medication review may be used e.g. STOPP/START, Strand or MAI) and discuss potential and actual problems with patient and prescriber. The regime should be designed around the patient's lifestyle and preferences, not just simplified by the pharmacist.</p>								

Problem or concern identified		Potential forms of support	
Eyesight	e.g. Registered blind / partially sighted Ability to read labels / reminder chart	<p>Brand recognition: where patients rely on distinctive packaging livery, document as a need on drug chart and in electronic clinical notes.</p> <p>Large print labels: suitable if can read larger script, e.g. 20 point:</p> <p>Take TWO tablets THREE times daily</p> <p>Talking labels: Reusable. One off initial cost covered by hospital, but there is a need to consider who will transfer the labels to new medicine boxes each month (carer, community pharmacy, family)</p>	
Dexterity / swallowing	e.g. Ability to open blister strips, MDS, CRCs. Ability to pour water, swallow solid dose forms, use drops, inhalers etc.	<p>Consider alternative: medicine, dosage form, inhaler device, Haleraid® etc.</p> <p>New technique: fingernail/teaspoon to open blister pack, double sip or Pill-glide® to aid swallowing, assess inhaler technique.</p> <p>Consider eye drop delivery devices e.g. Opticare®, and Opticare Arthro®. Document brand name of the device.</p>	
Specifically for eye drops	Ability to accurately get the drop into the eye Ability to squeeze the bottle to deliver the drop		
Understanding	e.g. Unable to understand English Unable to understand instructions Does not know what their medicines are for, or cannot describe regime	<p>Prompt card: list of all medication, and reason for use, reminds people which tablets to take and when. Only pharmacy staff should produce these.</p> <p>Picture labels: for example, a moon for night time dose.</p> <p>Interpreter: use the hospital service rather than relatives.</p> <p>MUR or NMS: refer to community pharmacy for follow up after discharge.</p>	
Memory	e.g. Is continuity of supply a problem? Forgetting to order? Forget to take medicines?	<p>Check that patient understands the value added to their health by this medicine.</p> <p>Consider options to improve memory:</p> <ul style="list-style-type: none"> ○ Linking tablet taking with another activity i.e. making a cup of tea, the 6pm news, etc. ○ recording tablet taking i.e. on a calendar <p>Prompt card: see description above in 'Understanding'.</p> <p>Medibox: may be suitable if regimen is complex, or a carer is prompting medication, but medicines are then off-license and many medicines are not stable in mediboxes. Some people dislike the loss of knowledge & control over their medicines.</p> <p>Prescription repeat, collection and delivery service: refer to community pharmacy to initiate.</p>	
Access	e.g. Cost of medicines Immobility or exercise intolerance	<p>Consider combination products.</p> <p>Prescription repeat, collection and delivery service: liaise/refer to community pharmacy to initiate.</p>	
Concerns about medicines or informed decision NOT to take medicines		Empathetically explore reasons to ensure that patient has all the risk/benefit information they need to make the right decision for them.	
Other identified issue			
Notes + Actions agreed with patient / carer to reduce the limitations to adherence:			
Notes			
Consider if there any potentially reversible causes of confusion or poor memory present. For example, history of alcohol use, signs of acute infection, drug therapy, hyponatraemia or recent head trauma.			
Any deficiency in performance on Mini-COG test indicates that a person is not competent to fill their own medibox. Be aware that this person may also not be able to give informed consent e.g. for services.			
Refer to community pharmacist for NMS/MUR if patient has new medicine(s) or any ongoing need for support.			
Sign	Print Name	Designation Clinical Pharmacist	Date

REACH: Pharmaceutical Care Bundles

Medicines linked with hospital admission & readmission

High Risk Medicine Group	Pharmaceutical Care Bundle
<p>ANTICOAGULANTS <i>Tinzaparin</i></p> <p>[NPSA - Reducing treatment dose errors with low molecular weight heparins (LMWH) (Rapid Response Report, July 2010)]</p>	<ul style="list-style-type: none"> • Check indication, patient weight and renal function for patients provided treatment doses of LMWH. • If for discharge: <ul style="list-style-type: none"> ○ Check patient/carer can self-administer (including how to give a part syringe without removing air bubble) or district nurse (DN) has been informed. ○ Check that duration of therapy after discharge & supply is appropriate and understood by patient/carer/DN.
<p>ANTICOAGULANTS <i>Warfarin & Coumarins</i></p> <p>[NPSA - Actions that can make anticoagulant therapy safer (Patient Safety Alert, March 2007)]</p>	<ul style="list-style-type: none"> • Ensure inpatient is managed appropriately using Trust guideline. • If new prescription for an indication where NOACs are licensed, check patient was involved in choice of anticoagulant using patient decision aids at www.patient.co.uk. • Complete the Trust inpatient anticoagulation counseling checklist with the patient and file in medical notes. • Ensure patient knows dose on discharge and when to expect/attend for monitoring. • Ensure appropriate follow up has been arranged post discharge. • Physically check yellow book completed before patient leaves hospital and that patient knows to carry alert card on their person. • DATIX report any poorly prescribed or inappropriately omitted doses.
<p>ANTICOAGULANTS <i>Non-vitamin K Oral Anticoagulants (NOACs)</i></p>	<ul style="list-style-type: none"> • Check dose is appropriate for age and renal function. • If new prescription for an indication where NOACs are licensed, check patient was involved in choice of anticoagulant using patient decision aids at www.patient.co.uk. • Check patient aware of danger signs (bleeding), and what to do. • Complete the Trust inpatient anticoagulation counseling checklist with the patient and file in medical notes. • Give patient a NOAC alert card (generic or from manufacturer) to carry on their person.
<p>HYPOGLYCAEMIC AGENTS <i>Insulin</i></p> <p>[NPSA Safer administration of insulin (Rapid Response Report, June 2010)]</p>	<ul style="list-style-type: none"> • Clinical medication review must include review of blood glucose results. • Review and complete insulin passport if patient chooses to carry one. • Provide information from/ signpost to 'NHS and Diabetes' at www.diabetes.co.uk/nhs. • DATIX report any poorly prescribed or inappropriately omitted doses.

<p>Oral hypoglycaemic agents</p>	<ul style="list-style-type: none"> • Check patient knows the signs and symptoms of hypoglycaemia, and has a reasonable plan of action if they feel a 'hypo' coming on. • Provide information from/ signpost to 'NHS and Diabetes' at www.diabetes.co.uk/nhs.
<p>ANTIMICROBIALS</p>	<ul style="list-style-type: none"> • Ensure choice and dose appropriate with regard to indication/GFR/sensitivities – guideline/microbiologist advice. • Ensure that indication stated is correct and current. • Ensure course length/review date is clearly stated and appropriate. • If necessary, ensure TDM is carried out at appropriate points throughout the course, and instructions for further monitoring are communicated on discharge. See Trust Pharmacy TDM guidelines for more information. • Suspend proton pump inhibitor (PPI) unless benefits outweigh risk. See Trust PPI prescribing guideline for more information. • Ensure patient is aware at discharge of duration, need to complete course and any drug-specific points e.g. diarrhoea with clindamycin, food/drug interactions with linezolid.
<p>CORTICOSTEROIDS <i>Inhaled</i></p>	<ul style="list-style-type: none"> • Check & give advice on patient's use of inhalers/nebuliser using Teach-Back® technique. • COPD – Consider rescue packs of steroid/antibiotic for home if appropriate and acceptable to patient and prescriber.
<p>CORTICOSTEROIDS <i>Oral</i></p>	<ul style="list-style-type: none"> • Ensure patient-held records are completed/up to date. • Talk with patient about use, benefits, side effects and 'danger' symptoms. Consider using NMS template for discussion. • FRAX assessment if patient falls/is at risk of falls and consider fracture prophylaxis if appropriate and acceptable to patient and prescriber. • If prescribed PPI, risk vs benefit discussion with patient and prescriber.
<p>ANTIEPILEPTIC MEDICATIONS</p>	<ul style="list-style-type: none"> • If therapeutic drug monitoring is necessary, advise non-specialist prescribers about dose changes and monitoring interval if levels are not within desired range. • Monitor patient closely whilst unwell for deterioration in renal function, serum sodium level and drug interactions. • Confirm and annotate drug chart with drug brand name. • Communicate serum levels, how drug interactions have been managed and monitoring recommendations to GP on discharge prescription.
<p>ANTIPSYCHOTICS</p>	<ul style="list-style-type: none"> • Ensure specific indication is documented on prescription. • If short term prescription (e.g. delirium): <ul style="list-style-type: none"> ○ Ensure ongoing need is reviewed weekly using Trust antipsychotic review guideline. ○ Consider giving the patient a knitted comforter. ○ Make patient decision aid from patient.co.uk available to next of kin so they can be involved in decision to use drug therapy. • If needed at or after discharge, ensure specific indication and

	start/review dates are communicated to GP.
<p>LITHIUM</p> <p>[NPSA -Safer lithium therapy (Patient Safety Alert, December 2009) and Trust Pharmacy TDM guidelines]</p>	<ul style="list-style-type: none"> • Ensure serum level has been requested unless checked and satisfactory within last three months. • Confirm and annotate drug chart with lithium brand. • Monitor patient closely whilst unwell for deterioration in renal function, serum sodium level and drug interactions. • Talk with patient about factors influencing adherence unless that was done earlier as part of Medicines Support Needs Assessment. • Check that medication regimen fits patient's lifestyle, values and preferences. Discuss any problems identified with the patient's mental health professional. • Complete a medication reminder card with the patient, using their preferred terminology.
<p>ANTIDEPRESSANTS</p>	<ul style="list-style-type: none"> • Talk with patient about factors influencing adherence unless that was done earlier as part of Medicines Support Needs Assessment. • Check that medication regimen fits patient's lifestyle, values and preferences. Discuss any problems identified with the patient's mental health professional. • Complete a medication reminder card with the patient, using their preferred terminology.
<p>OPIOIDS</p> <p>[NPSA Reducing dosing errors with opioid medicines. Rapid Response Report, July 2008]</p>	<ul style="list-style-type: none"> • Prioritise medicine reconciliation for patients prescribed strong opioids, following Trust procedure. <ul style="list-style-type: none"> ○ Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient with two sources, the patient being one source wherever possible. • Check the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, and common side effects of that medicine and formulation. • Ensure where a dose increase is intended, that the calculated dose is safe for the patient. <ul style="list-style-type: none"> ○ Ensure dose increase is not more than 50% higher than previous dose. ○ Clinical medication review must be carried out at every dose increase including a discussion with patient about their pain control, pain management preferences and side effects.