

The Evaluation of Auckland District Health Board's Medicines Use Review Pilot:

Appendices for the ADMiRE Report

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MEDICINES REVIEW – PHARMACIST CONSULTATION RECORD

Patient details

Title (circle)	Mr	Mrs	Miss	Ms	Dr	Other:	Address	Phone	
Surname:									
First name									
Gender(circle):	M	F							Patient's GP (NZMC #)
NHI number:									
DOB									Postcode above (separate):
Pharmacy ID									

Initial referral from:

Ethnicity (tick- multiples allowed)

New Zealand European	
Maori	
Samoan	
Cook Island Maori	
Tongan	
Niuean	
Chinese	
Indian	
Other (specify)	

Criteria for inclusion (tick all that apply)

Living independently in the community	
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AND at least ONE of the following:

Taking three or more prescribed medications or more than 12 doses per day	
More than one prescriber	
Recent hospital admission (within 4 weeks)	
Taking medicines with a high risk of adverse effects or need for monitoring	

AND identified or suspected to be experiencing or being at high risk of medicines related problems (tick those applicable)

Medicines non – adherence	
Confusion about the medicines regimen	
Medicines management issues dues to impaired sight, reduced dexterity, literacy or language difficulties, cognitive difficulties	
Adverse effects of prescribed medicines	
Sub-optimal response to pharmacotherapy	

Initial Review**Pharmacy ID:****INITIAL REVIEW DETAILS**

Date:	Name of pharmacist:
Venue (circle one): Pharmacy Patient's home Other(specify)	Duration of visit (minutes):

Health Conditions

Condition	tick	Source of information
Cardiovascular disease (incl. angina & CHF)		
Muscular/skeletal (incl. arthritis)		
Respiratory disease (incl. COPD & asthma)		
Diabetes		
(Other)		
(Other)		

Alcohol and Smoking			
Standard drinks per week:			
Comments:			
Smoking status (circle one)	Never	Current	Ex*
Number of packs per day			
Comments			
*indicate how long an ex smoker:			

Factors that may influence medicines use or effectiveness (provide details)
Mobility
Eyesight
Hearing

Pre-interview checklist (tick each one):	
Patient's pharmacy medication record printed out	
Introduction and explanation of service completed	
Consent form signed	
Patient has made all current medications, supplements etc available	

Initial Review

Pharmacy ID:

MEDICATION LIST

Prescription Medicines page 1

Regular Medicines <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Adherence** How often do you miss a dose of this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge					
**Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose					

Initial Review

Pharmacy ID:

Prescription Medicines page 2

Regular Medicines <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Adherence** How often do you miss a dose of this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge					
**Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose					

Initial Review

Pharmacy ID:

As Required and Short Course Medicines

<ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Indication	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge					

Initial Review**Pharmacy ID:****THERAPEUTIC RESPONSE**

Question	Patient Response/Notes
Do you think the medicines your doctor prescribes are working for you? <ul style="list-style-type: none"> • Are there any that don't seem to be working well? 	

How strongly do you agree or disagree with this statement? (circle one response only)

The medicines my doctor prescribes work well for me	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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Initial Review**Pharmacy ID:****MEDICINE ADHERENCE**

Thinking of the medications PRESCRIBED to you by your doctor(s), please answer the following questions.

	Never	Rarely	Sometimes	Often	Always
Do you ever forget to take your medications?	0	1	2	3	4
Are you careless at times about taking your medications?	0	1	2	3	4
When you feel better, do you sometimes stop taking your medications?	0	1	2	3	4
Sometimes, if you feel worse when you take your medications, do you stop taking them?	0	1	2	3	4

Question	Patient Response/Notes
How do you usually remind yourself to take your medicines on time?	
What do you do if you miss a dose?	

Initial Review**Pharmacy ID:****MEDICINES USE – PRACTICAL ASPECTS**

Question	Patient Response/Notes
Do you have any difficulty reading labels on your medicines?	
Do you have any problems removing medicines from containers or the packaging?	
Do you have any problems with taking or using your medicines? eg swallowing tablets, using eye drops, applying transdermal patches, using inhalers	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily take or use my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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Initial Review**Pharmacy ID:****MEDICINES ACCESS/SUPPLY**

Question	Patient Response/Notes
How do you collect your medicines?	
How do you organise the further supply of medicines, including repeats?	
Do you ever run out of your medicines before you get the next supply? If so, why do you think this happens?	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily order and collect my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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MEDICINES EXPIRED/WASTE

Do you have any medicines that you no longer use or no longer want that I could dispose of safely for you?	
--	--

QUALITY OF LIFE

By placing a tick in one box in each group below, please indicate which statements best describe your own health state **today**.

Mobility

I have no problems in walking about

I have some problems in walking about

I am confined to bed

Self-Care

I have no problems with self-care

I have some problems washing or dressing myself

I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

Pain/Discomfort

I have no pain or discomfort

I have moderate pain or discomfort

I have extreme pain or discomfort

Anxiety/Depression

I am not anxious or depressed

I am moderately anxious or depressed

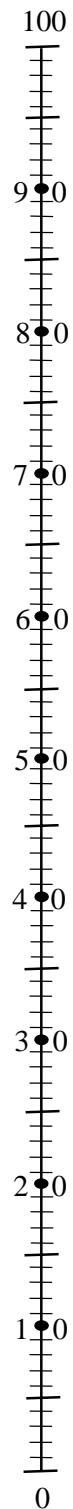
I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state
today**

Best
imaginable
health state



Worst
imaginable
health state

Initial Review**Pharmacy ID:****POST INTERVIEW REVIEW: ISSUES IDENTIFIED**

		Comments	Reassess at follow up Y/N
Prescribed Medicines Adherence			
	Poor Adherence		
	Missed Doses (unintentional)		
	Skipped/Changed Doses (intentional)		
	Confusion about regime		
	Concerns about medicines		
	Other		
Therapeutic Response (patient perception)			
	Lack of Confidence in Rx Medicines		
	Lack of Knowledge in Rx Medicines		
	Inadequate control of symptoms		
	Taking OTC meds or supplements to augment Rx meds		
	Other		
Practical Medicines Use			
	Vision-reading labels		
	Manual dexterity – opening containers or removing medicine from packaging		
	Understanding label instructions		
	Literacy/English Skills		
	Using dosage forms		
	Other		
Access/Supply			
	Ordering repeats or collecting medicines		
	Medicines not synchronised		
	Hoarding of medicines		
	Prescription costs		
	Other		
Expired/Unwanted Medicines			
	Expired Medicines	Please insert details	
	Unwanted Medicines		
	Unidentifiable Medicines		

Initial Review**Pharmacy ID:****POST INITIAL REVIEW: PHARMACISTS' OVERALL PERCEPTION OF PATIENT'S MEDICINE KNOWLEDGE**

Using the information gathered from the interview (prescribed and as required regimen versus the patient's reported regimen) please rate the Patient's overall knowledge of :

Knowledge area:	Knowledge score* (1 to 4)
Why their medicines have been prescribed	
The patient knows when to take their medicines	
The patient knows how to take/use their medicines (including any special instructions/precautions)	
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge	

Initial Review**Pharmacy ID:****MEDICATION MANAGEMENT PLAN**

date plan was filled in: ___/___/___

Y/N	Action/Intervention	Details/comments	Initial and date when item implemented
	Patient education/counselling (tick as req.)		
	Counselling		
	Written info		
	Demonstration		
	Other		
	Blister packaging		
	Adherence monitoring		
	Medicine packaging, or labelling change		
	Removal of unwanted/expired medicines		
	Referral to other service, or health practitioner		
	Other		

Follow up 1**Pharmacy ID:****FOLLOW UP 1 DETAILS**

Date:	Name of pharmacist:
Venue (circle one): Pharmacy Patient's home Other(specify)	Duration of visit (minutes):

Health Conditions (note changes since initial interview)

Condition	tick	Source of information
Cardiovascular disease (incl. angina & CHF)		
Muscular/skeletal (incl. arthritis)		
Respiratory disease (incl. COPD & asthma)		
Diabetes		
(Other)		
(Other)		

Alcohol and Smoking (since initial interview)

Standard drinks per week:	
Comments:	
Smoking status (circle one)	Never Current Ex*
Number of packs per day	
Comments	
*indicate how long an ex smoker:	

Factors that may influence medicines use or effectiveness (provide details)

Mobility
Eyesight
Hearing

Pre-follow up checklist (tick each one):

Patient's current pharmacy medication record printed out	
Patient has made all current medications, supplements etc available	
Medication record printed and ready to give to patient	

Follow up 1**Pharmacy ID:****MEDICATION LIST****Prescription Medicines page 1**

Regular Medicines <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Adherence** How often do you miss a dose of this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge **Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose					

Follow up 1

Pharmacy ID:

Prescription Medicines page 2

<p>Regular Medicines</p> <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	<p>Taken as directed</p>	<p>Tick 'as directed' or comment here if patient regimen differs</p>	<p>Knowledge* Why are you prescribed this medicine?</p>	<p>Adherence** How often do you miss a dose of this medicine?</p>	<p>Additional comments</p>
<p>*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge</p> <p>**Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose</p>					

Follow up 1

Pharmacy ID:

As Required and Short Course Medicines

<ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Indication	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Additional comments

*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge

Follow up 1**Pharmacy ID:****THERAPEUTIC RESPONSE**

Question	Patient Response/Notes
Do you think the medicines your doctor prescribes are working for you? <ul style="list-style-type: none"> • Are there any that don't seem to be working well? 	

How strongly do you agree or disagree with this statement? (circle one response only)

The medicines my doctor prescribes work well for me	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
---	-------------------	----------	---------------------------	-------	----------------

Follow up 1**Pharmacy ID:****MEDICINE ADHERENCE**

Thinking of the medications PRESCRIBED to you by your doctor(s), please answer the following questions.

Since the initial interview	Never	Rarely	Sometimes	Often	Always
Do you ever forget to take your medications?	0	1	2	3	4
Are you careless at times about taking your medications?	0	1	2	3	4
When you feel better, do you sometimes stop taking your medications?	0	1	2	3	4
Sometimes, if you feel worse when you take your medications, do you stop taking them?	0	1	2	3	4

Question	Patient Response/Notes
How do you usually remind yourself to take your medicines on time?	
What do you do if you miss a dose?	

Follow up 1**Pharmacy ID:****MEDICINES USE – PRACTICAL ASPECTS**

Question	Patient Response/Notes
Do you have any difficulty reading labels on your medicines?	
Do you have any problems removing medicines from containers or the packaging?	
Do you have any problems with taking or using your medicines? e.g. swallowing tablets, using eye drops, applying transdermal patches, using inhalers	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily take or use my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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Follow up 1**Pharmacy ID:****MEDICINES ACCESS/SUPPLY**

Question	Patient Response/Notes
How do you collect your medicines?	
How do you organise the further supply of medicines, including repeats?	
Do you ever run out of your medicines before you get the next supply? If so, why do you think this happens?	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily order and collect my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
---	-------------------	----------	---------------------------	-------	----------------

MEDICINES EXPIRED/WASTE

Do you have any medicines that you no longer use or no longer want that I could dispose of safely for you?	
--	--

Quality of Life

By placing a tick in one box in each group below, please indicate which statements best describe your own health state **today**.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (*e.g. work, study, housework, family or leisure activities*)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

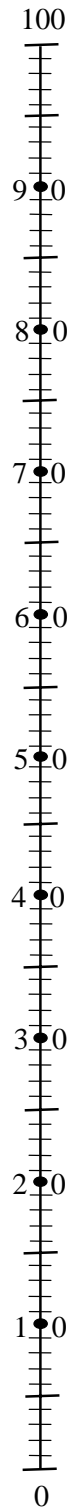
- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state
today**

Best
imaginable
health state



Worst
imaginable
health state

Follow up 1**Pharmacy ID:****FOLLOW UP ISSUES FROM INITIAL REVIEW AND NEW ISSUES**

Date:	Pharmacist:	
Issue reassessed at follow up (from Issues Identified)	Outcome	
	Reassess at follow up 2? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess at follow up 2? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess at follow up 2? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess at follow up 2? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess at follow up 2? (Yes or No)	

Follow up 1**Pharmacy ID:**

New Issue	Details	
	Reassess at follow up 2? (Yes or No)	
New Issue	Details	
	Reassess at follow up? 2 (Yes or No)	
New Issue	Details	
	Reassess at follow up? 2 (Yes or No)	
New Issue	Details	
	Reassess at follow up? 2 (Yes or No)	
New Issue	Details	
	Reassess at follow up? 2 (Yes or No)	

Follow up 1**Pharmacy ID:****POST FOLLOW UP 1: PHARMACISTS' OVERALL PERCEPTION OF PATIENT'S MEDICINE KNOWLEDGE**

Using the information gathered from the interview (prescribed and as required regimen versus the patient's reported regimen) please rate the Patient's knowledge of :

Knowledge area:	Knowledge score* (1 to 4)
Why their medicines have been prescribed	
The patient knows when to take their medicines	
The patient knows how to take/use their medicines (including any special instructions/precautions)	
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge	

Follow up 2**Pharmacy ID:****FOLLOW UP 2 DETAILS**

Date:	Name of pharmacist:
Venue (circle one): Pharmacy Patient's home Other(specify)	Duration of visit (minutes):

Health Conditions (note changes since follow up 1)

Condition	tick	Source of information
Cardiovascular disease (incl. angina & CHF)		
Muscular/skeletal (incl. arthritis)		
Respiratory disease (incl. COPD & asthma)		
Diabetes		
(Other)		
(Other)		

Alcohol and Smoking (since follow up 1)			
Standard drinks per week:			
Comments:			
Smoking status (circle one)	Never	Current	Ex*
Number of packs per day			
Comments			
*indicate how long an ex smoker:			

Factors that may influence medicines use or effectiveness (provide details)
Mobility
Eyesight
Hearing

Pre-follow up checklist (tick each one):	
Patient's current pharmacy medication record printed out	
Patient has made all current medications, supplements etc available	

Follow up 2**Pharmacy ID:****MEDICATION LIST****Prescription Medicines page 1**

Regular Medicines <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Adherence** How often do you miss a dose of this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge					
**Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose					

Follow up 2

Pharmacy ID:

Prescription Medicines page 2

Regular Medicines <ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	Taken as directed	Tick 'as directed' or comment here if patient regimen differs	Knowledge* Why are you prescribed this medicine?	Adherence** How often do you miss a dose of this medicine?	Additional comments
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge **Adherence: 1 = Always miss a dose 2= Often miss a dose 3= Seldom miss a dose 4= Never miss a dose					

Follow up 2

Pharmacy ID:

As Required and Short Course Medicines

<ul style="list-style-type: none"> • Drug name • Dosage form and strength • Dose and freq. • Directions – from label 	<p style="text-align: center;">Indication</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Taken as directed</p>	<p style="text-align: center;">Tick 'as directed' or comment here if patient regimen differs</p>	<p>Knowledge* Why are you prescribed this medicine?</p>	<p style="text-align: center;">Additional comments</p>
<p>*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge</p>					

Follow up 2**Pharmacy ID:****THERAPEUTIC RESPONSE**

Question	Patient Response/Notes
Do you think the medicines your doctor prescribes are working for you? <ul style="list-style-type: none"> • Are there any that don't seem to be working as well? 	

How strongly do you agree or disagree with this statement? (circle one response only)

The medicines my doctor prescribes work well for me	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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Follow up 2**Pharmacy ID:****MEDICINE ADHERENCE**

Thinking of the medications PRESCRIBED to you by your doctor(s), please answer the following questions.

Since the last follow up:	Never	Rarely	Sometimes	Often	Always
Do you ever forget to take your medications?	0	1	2	3	4
Are you careless at times about taking your medications?	0	1	2	3	4
When you feel better, do you sometimes stop taking your medications?	0	1	2	3	4
Sometimes, if you feel worse when you take your medications, do you stop taking them?	0	1	2	3	4

Question	Patient Response/Notes
How do you usually remind yourself to take your medicines on time?	
What do you do if you miss a dose?	

Follow up 2**Pharmacy ID:****MEDICINES USE – PRACTICAL ASPECTS**

Question	Patient Response/Notes
Do you have any difficulty reading labels on your medicines?	
Do you have any problems removing medicines from containers or the packaging?	
Do you have any problems with taking or using your medicines? e.g. swallowing tablets, using eye drops, applying transdermal patches, using inhalers	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily take or use my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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Follow up 2**Pharmacy ID:****MEDICINES ACCESS/SUPPLY**

Question	Patient Response/Notes
How do you collect your medicines?	
How do you organise the further supply of medicines, including repeats?	
Do you ever run out of your medicines before you get the next supply? If so, why do you think this happens?	

How strongly do you agree or disagree with this statement? (circle one response only)

I can easily order and collect my medicines	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
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MEDICINES EXPIRED/WASTE

Do you have any medicines that you no longer use or no longer want that I could dispose of safely for you?	
--	--

Quality of Life

By placing a tick in one box in each group below, please indicate which statements best describe your own health state **today**.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state
today**

Best
imaginable
health state

100



90



80



70



60



50



40



30



20



10



0



Worst
imaginable
health state

Follow up 2**Pharmacy ID:****FOLLOW UP ISSUES FROM FOLLOW UP 1 AND NEW ISSUES**

Date:	Pharmacist:	
Issue reassessed at follow up	Outcome	
	Reassess again? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess again? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess again? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess again? (Yes or No)	
Issue reassessed at follow up	Outcome	
	Reassess again? (Yes or No)	

Follow up 2**Pharmacy ID:**

New Issue	Details	
	Reassess again? (Yes or No)	
New Issue	Details	
	Reassess again? (Yes or No)	
New Issue	Details	
	Reassess again? (Yes or No)	
New Issue	Details	
	Reassess again? (Yes or No)	
New Issue	Details	
	Reassess again? (Yes or No)	

Follow up 2**Pharmacy ID:****POST FOLLOW UP 2: PHARMACISTS' OVERALL PERCEPTION OF PATIENT'S MEDICINE KNOWLEDGE**

Using the information gathered from the interview (prescribed and as required regimen versus the patient's reported regimen) please rate the Patient's knowledge of :	
Knowledge area:	Knowledge score* (1 to 4)
Why their medicines have been prescribed	
The patient knows when to take their medicines	
The patient knows how to take/use their medicines (including any special instructions/precautions)	
*Knowledge: 1 = No knowledge 2= Some knowledge 3= Good knowledge 4= Excellent knowledge	

Contract Description

10. Do you have a name for the ADHB service contract?

11. Who is/ will be directly involved in delivering the contract? (key contact/alternate)

a. describe the roles and responsibilities in the service

12. Who will use the new service?

a. How are they referred or chosen?

b. What criteria do they have to comply with?

c. How do you check their eligibility (if you will)

d. For the DHB

e. Anyone else?

14. What do you expect might be potential barriers to success?

15. What will the new service do?

a. Describe the process

b. Is there an initial consultation?- when, how long, what will you ask?

c. When will you do a follow up? How often? By whom?

d. Do you have a criteria for additional assessments (e.g. ADE's)

16. What do you hope this service will change?

a. For the client

b. For you

c. For the community

d. Anyone else?

17. What methods of recording information are you intending to use?

a. Electronic, paper-based, open ended notes

b. Are you happy to share all information with the evaluation group? (is there any information you feel concerned about?)

Pharmacist interview 1 draft 1 230108

ADMIRE Project: Pharmacist Interview 1 Schedule

Date:	
Interviewee	
Interviewer	

- Explain the rationale for these interviews- finding out about the implementation of the service from the pharmacist's perspective
- Reminder regarding anonymity of information, including from Guild Project Manager
- Go over the schedule of three interviews- Preparation phase, the MURs, overall barriers/advantages of MUR

Pharmacist preparation, training and funding	
Q1	<p>To start, could you just remind me about your previous experiences in providing community based or other extended patient services?.</p> <ul style="list-style-type: none"> • Patient funded or DHB/govt. funded? • Needle exchange, cholesterol testing, ECP etc
Q2	Why did you take on the current project?

Pharmacist interview 1 draft 1 230108

Q3	<p>What did you do to prepare for the project?</p> <ul style="list-style-type: none">• Training for you or staff (Guild or self motivated)• Additional staff• Additional resources (if yes- what?)• Review patients

Pharmacist interview 1 draft 1 230108

Q4	<p>What do you think about the contracting process for the project?</p> <ul style="list-style-type: none">• Timeframe to set up contract• Information provided by the Guild• Contract documentation (was there any?)• Remuneration• Set up and training support
Q5	<p>Is there anything else you'd like to say about the training for and the contracting of the MUR service?</p>

Pharmacist interview 1 draft 1 230108

Recruiting patients	
Q6	How did you decide which patients to offer an MUR?
<ul style="list-style-type: none">• Set criteria? If yes, what?• Audit of existing patients	
Q7	Tell me about the recruitment process
<ul style="list-style-type: none">• How did you approach people- in pharmacy, phone, letter?• Did they agree/refuse/want more information?• If wanted more- why?• If refused-why?• Was it easy/hard to recruit enough patients?- why do think that was?	

Pharmacist interview 1 draft 1 230108

Q8	Do you have any further comments

THANK YOU FOR YOUR TIME

Pharmacist interview 2 draft 2 290708

ADMiRE Project: Pharmacist Interview 2 Schedule

Date:	
Interviewee	
Interviewer	

Q1	<p>First off, I'd like you to talk me through two patients you recruited and interviewed. Thinking about the patient you felt was the most successful-</p> <ul style="list-style-type: none">• Recruitment- when and how• Contact, communication• The visit(s)

Pharmacist interview 2 draft 2 290708

Q2	<p>Now thinking about the patient you felt was the greatest challenge-</p> <ul style="list-style-type: none">• Recruitment- when and how• Contact, communication• The visit(s)

Pharmacist interview 2 draft 2 290708

Q3	Thinking about all the MUR patients, what benefits of MUR have you seen?

Pharmacist interview 2 draft 2 290708

Q4	What benefits have you experienced for yourself and your practice?

Pharmacist interview 2 draft 2 290708

Q5	<p>Each pharmacist was expected to recruit and interview 25 patients between November 2007 and June 1st 2008.</p> <ul style="list-style-type: none">• Was this target realistic?• What challenges and barriers made this target difficult?<ul style="list-style-type: none">○ Staff turnover○ Existing workload○ Others• (for each) was it an existing barrier (e.g. staff turnover) or a new one?

Pharmacist interview 2 draft 2 290708

Q6	Recruitment issues <ul style="list-style-type: none">• Did you have a systematic approach or just ask those who walked in the door?
Q7	What would have helped achieve that target? <ul style="list-style-type: none">• More/better/different support• Extra staff• Better payment• More suitable patients to recruit

Pharmacist interview 2 draft 2 290708

Q8	<p>What did you think about the paper-based interview tool?</p> <ul style="list-style-type: none">• What improvements would you like to see?• What was missing• What could have been left out?

Pharmacist interview 2 draft 2 290708

Q9	If you were to talk to a colleague about taking on an MUR service contract, how would you describe it?

Pharmacist interview 2 draft 2 290708

Q10	<p>What changes might help you provide an MUR service in the future?</p> <ul style="list-style-type: none">• Support• Training• Infrastructure

Pharmacist interview 2 draft 2 290708

Q11	Did you attend the MUR training? (December- run by College of Pharmacists) Was it helpful? How have you found the accreditation process How has this training and/or accreditation impacted on your MUR pilot?

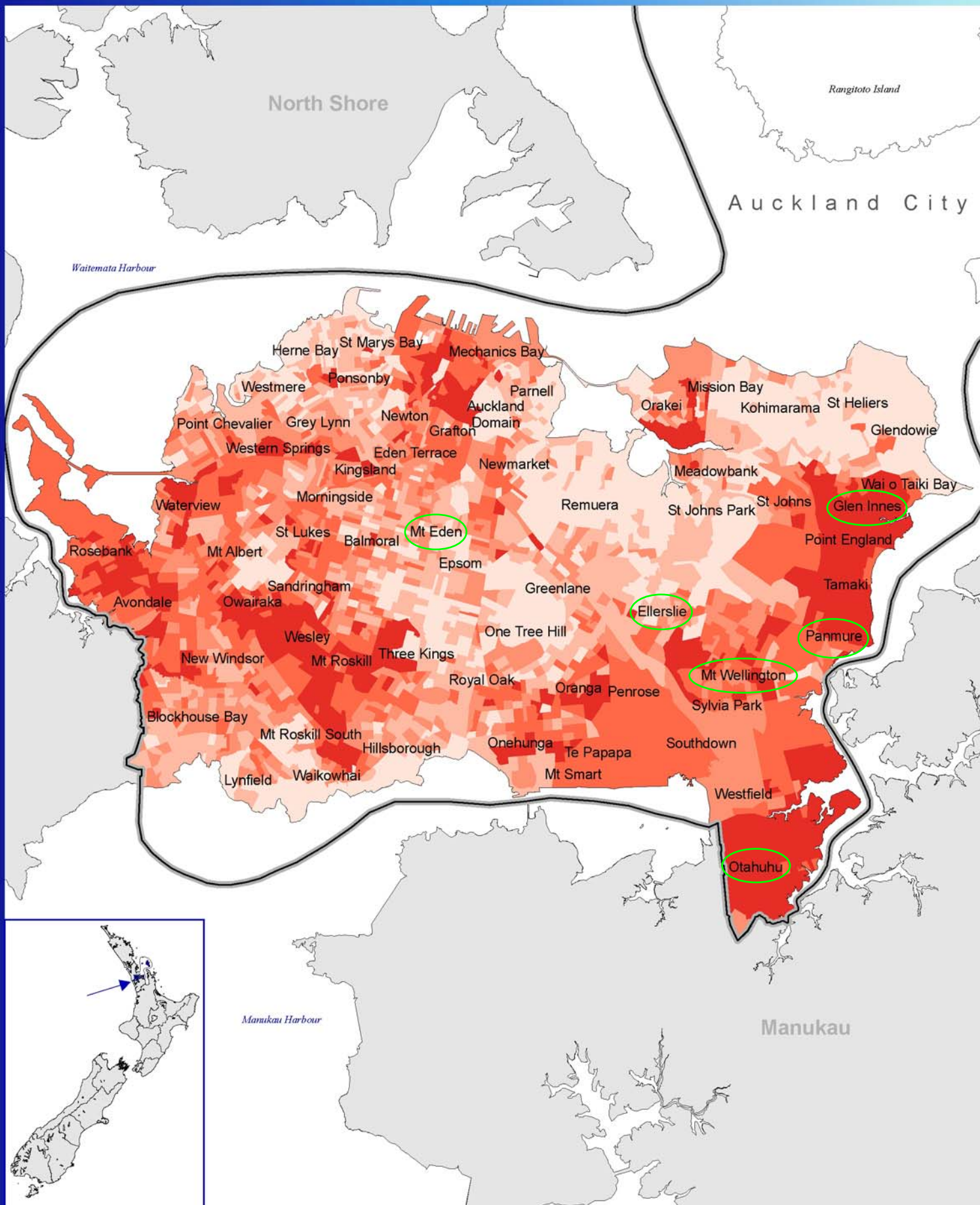
Pharmacist interview 2 draft 2 290708

Q12	Do you have any further comments

THANK YOU FOR YOUR TIME

Auckland DHB NZDep2006

Atlas of Socioeconomic Deprivation in New Zealand NZDep2006



White P, Gunston J, Salmond C, Atkinson J, Crampton P. 2008.
Atlas of Socioeconomic Deprivation in New Zealand NZDep2006
Wellington: Ministry of Health.

Public Health Intelligence
Charting our Health
www.moh.govt.nz/phi
Health & Disability
Systems Strategy Directorate
Ministry of Health
Data Sources:
Ministry of Health
University of Otago
Statistics NZ

June 2008



MANATŪ HAUORA

ANNUAL MEDICATION REVIEW

Appendix page 71 of 77

NAME: [redacted]

DOB:

NHI NO

ALLERGIES:

This field was not present. Please check. Annotate if no known drug allergies- NKDA.

SELWYN AREA: Sarah Selwyn

MEDICATION:

See attached drug chart for medications.

INTERACTIONS:

● Tramadol and Warfarin: increased anticoagulant effect. Take this in to consideration when Tramadol is added "prn" or regularly.

BLOOD TESTS/LABS RELEVANT TO MEDICATIONS:

- Serum Iron and Haemoglobin.
- May wish to check electrolytes particularly sodium and potassium. These levels may be low due to regular Frusemide.
- Lipid profile.
- Blood pressure. Mrs JD may experience hypotension due to Oxycodone addition.
- Renal and hepatic function- to ensure dose of Oxycodone appropriate. Oxycodone can precipitate coma in hepatic impairment.

NEW MEDICATIONS POTENTIALLY INDICATED:

- Colecalciferol 1.25mg ONCE a month. Most elderly are deficient in Vitamin D and it is essential for calcium absorption.
- Calcium carbonate 1250mg ONCE daily with food. (Calcium has been shown to reduce hip and vertebral fracture when used in combination with Vitamin D.)
- Bisphosphonate. Etidronate or Alendronate if patient meets special authority criteria or patient willing to pay. NB: Calcium would need to be dosed at lunchtime if given with Alendronate as it reduces Alendronate absorption. However if Etidronate is added Calcium would need to be stopped on the 2 weeks of every 3 months that Etidronate is given.
- Nitrolingual spray prn not charted. If has been prescribed in the past check expiry date. A pumpspray would be useful if she suffers from angina- suggested by her regular Isosorbide mononitrate.

CURRENT MEDICATIONS WITH POTENTIAL FOR REVIEW:

- Review Omeprazole. May wish to consider dose reduction. Long term use associated with renal impairment.
- Review Temazepam- change to prn? Following hospital admission Temazepam replaced Zopiclone. May wish to query why.
- Review pain relief. Currently taking regular Paracetamol and Tramadol. If not adequate control may wish to consider Morphine?
- Review Iron. Likely to be worsening constipation. Why is the Iron necessary? Underlying bleeding? Warfarin will exacerbate this if it is the case.
- Review Simvastatin. Is the lipid profile adequate or would Mrs JD benefit from increase an increase in dose.
- Review Blood pressure. If high could consider increasing Frusemide to 40mg daily or increasing Metoprolol to 95 mg daily.

OVERVIEW:

- Consider:
 - Colecalciferol
 - Calcium
 - Bisphosphonate
 - Glyceryl trinitrate pumpspray (prn)
- Review:
 - Omeprazole
 - Temazepam
 - Analgesia
 - Iron

Selwyn Foundation Evaluation Data Record

Please contact Theo Brandt on 021 376 478 for any questions

1. Pharmacist fills in pre-AMR and recommendation data
2. GP completes 'GP action on AMR' after Medical Review and sends back to Pharmacist
3. Pharmacist to enter information from current chart at the post 3 month point

Patient details

Gender(circle):	M	F
NHI number:		
DOB		
ADMIRE ID		

Selwyn Area
Patient's GP

Event record

Event	Date	Pharmacist or GP name
Initial AMR		
Date of GP consultation/review		
Date of 3 month review		

Tests and allergies

Blood tests recommended in AMR	Y / N	GP orders blood test	Y / N
Allergy status available for AMR	Y / N	Available at 3 month follow up	Y / N

Medications prescribed

	Pre-AMR Code*	GP action on AMR and comments- <i>please refer to guidelines page for guidance</i>	Post-AMR Code*
Aspirin			
Calciferol			
BBlocker			
ACEI or ARB's			
Bisphosphonates			
Calcium			
Fibre			
Sedatives			
Antidepressants- tricyclics			
Antidepressants- others			
Psychotropics			
Statins			
PPI's			
Warfarin			
Flixotide			
Other			
Other			
Other			
Other			
Other			
Other			

* No change to medication	N/C
Start medication	Start
Stop medication	Stop
Review medication	R

* Increase dosage	Inc
Decrease dosage	Dec
Change route	C/R
Other	Oth.

Evaluation of the ADHB Annual Medicines Review (AMR) Pilot

GP Questionnaire

Between August 2007 and October 2008, the Selwyn Foundation trialled the use of Annual Medicines Reviews (AMRs). Walls and Roche Pharmacy was contracted to undertake the reviews. They provided a list of recommendations based upon the patient's current medicines regimen. As a GP with patients living at a Selwyn facility, you will have received an AMR for each of your patients. You will have also received an evaluation sheet to record any comments or decisions you may have made regarding changes to your patients medications.

The School of Pharmacy at The University of Auckland was contracted to evaluate this AMR pilot. As part of the evaluation, we are interested in finding out your impressions of how useful you found the AMR for patient care, and if such a service was to be ongoing, what changes may be required.

We would appreciate you taking 10 minutes to fill in this brief questionnaire. We would also be very grateful for the opportunity to call a small number of GPs to explore any issues that might be identified. If you are willing to be interviewed, could you please send an email to me, Theo Brandt (Evaluation Project Manager): t.brandt@auckland.ac.nz

Please note that the questions below relate to TWO separate documents:

- The Annual Medicine Review (AMR) - the one to two page summary with recommendations from the Pharmacy.
- The Evaluation sheet - a single page with lists of medicines and tick boxes, titled "Selwyn Foundation Evaluation Data Record"
- These questions relate ONLY to patients under your care in Selwyn facilities

Basic demographics

Q1. Approximately how many patients are under your care in Selwyn facilities?	
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Q2. Approximately for what percentage of these patients did you receive an <i>AMR</i> ?									
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Q3. Approximately for what percentage of these patients did you receive an <i>Evaluation sheet</i> ?									
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Please go to next page...

Use of the AMR sheet

Q4. How often did you read the patient AMR summaries? (circle ONE)					
Always	Frequently	Occasionally	Rarely	Never	Not sure/NA

Q5. Overall, how useful did you find the AMR summaries? (circle ONE)					
Extremely useful	Very useful	Moderately useful	Slightly useful	Not at all useful	Not sure/NA

Q5a. Why was that? (please provide some brief comments)

Use of the Evaluation sheet

Q6. How often did you fill in the Evaluation sheets? (circle ONE)					
Always	Frequently	Occasionally	Rarely	Never	Not sure/NA

Q7. Overall, how useful did you find the Evaluation sheets? (circle ONE)					
Extremely useful	Very useful	Moderately useful	Slightly useful	Not at all useful	Not sure/NA

Q7a. Why was that? (please provide some brief comments)

Pharmacist's recommendations

Q8. How often did you **agree** with recommendations made by the pharmacist on the AMR or Evaluation sheet?

Always	Frequently	Occasionally	Rarely	Never	Not sure/NA
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Q9. How often did you **action** recommendations made by the pharmacist on the AMR or Evaluation sheet?

Always	Frequently	Occasionally	Rarely	Never	Not sure/NA
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Q9a. Why was that? (please provide some brief comments)

--

Benefits of AMR for your patients

Q10. How much do you agree that these were benefits of AMR for your patients:

(circle ONE number for each statement):

Benefit	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
Stopping of non-indicated medication	1	2	3	4	5
Increased preventative prescribing	1	2	3	4	5
Reduced number of hospital admissions	1	2	3	4	5
Increased patient awareness	1	2	3	4	5
Increased patient satisfaction	1	2	3	4	5
Increased patient compliance/adherence	1	2	3	4	5
A decrease in the total number of falls	1	2	3	4	5
A reduction in wastage of medication	1	2	3	4	5

Q10a. Please describe any other patient benefits you believe were a result of the AMR process:

--

Benefits of AMRs for the GP

Q11. How much do you agree that the AMRs were for you, the GP: (circle ONE number for each statement):

Benefit	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
A valuable overview of current medications	1	2	3	4	5
A waste of time	1	2	3	4	5
A valuable reminder of drug contraindications	1	2	3	4	5
A useful communication tool between Pharmacist and GP	1	2	3	4	5
A useful communication tool between patient and GP	1	2	3	4	5

Other benefits from AMR or the Evaluation sheet

Q11a. Please describe any other aspects of the **AMR** or **Evaluation data record** that benefited your work as a GP:

--

Q12. Would you like to see AMRs continued on an annual basis?	Yes	No
Q12a. Why is that? (please provide some brief comments)		
Q12b. If Yes, what would you like the AMR to look like? (e.g. 'as is', 'more like the Evaluation sheet'?)		

Q13. Do you have any other comments you would like to make?

THANKYOU FOR YOUR TIME AND OPINIONS

Please return to t.brandt@auckland.ac.nz

or Fax: 09 367 7192

or Postal: Theo Brandt, School of Pharmacy, FMHS, The University of Auckland,

Private Bag 92019, Auckland 1142

If you are happy to spend a further 10 – 15 minutes talking about the AMR process, please let me know by emailing me at the preceding email address.