Teignbridge PCT
Medication Administration Support Pilot
Assessment for Medicine Concordance – Devon
(Medicine-taking check – Pilot version Aug 04)

This assessment should be undertaken by a health or social care professional with appropriate training.

This tool is linked to the Single Assessment Process and designed to help health and social care professionals take a structured approach to assessing an individuals’ problems with their medicine.

People often have problems taking their medicines for a variety of reasons. Before appropriate help can be given it is important to know the nature of the underlying causes. Problems may be:

- Unintentional: people may want to take their medicines as prescribed, but there are barriers preventing them.
- Intentional: people may choose not to take their medicines as prescribed for various reasons.

The tool is designed to identify the different elements that should be addressed;

- Help received at home
- Exploring peoples’ understanding of their medication regime
- Exploring behaviour and attitude to medicine taking.
- Physical abilities.

How to use this assessment tool.

Those parts written in **bold** are direct questions needed to inform the decisions, however try to encourage the service user to talk about their problems comfortably. Open questions are suggested in *italics*.

The ‘action’ boxes following each section suggest solutions. Don’t be limited by these, where any other individual solutions are apparent please specify.

Category 1, Category 2 and Category 3 assistance refers to the “Medication Support Service Policy – Community Support Services (Domiciliary Care)”

A Monitored Dose System (MDS) may not be requested without a Level 2 or Level 3 medication review carried out by GP/Pharmacist/[Practice or District Nurse].

What to do with the completed assessment tool

The completed assessment tool will form part of the wider assessment either being carried out by yourself or another person. It is essential that the outcomes and recommendations inform any care plan and therefore where appropriate must be passed to that person. In addition to the list at the end of the form, a copy of the completed assessment should be given to the Service User/ patient for placing, with their agreement, in the Community Home Based Record.

Review and follow up

It may be appropriate to carry out a reassessment after a reasonable period to find out if the actions have been successful and if any new problems have arisen. Any review date will be determined and instigated by the manager, [community pharmacist] or General Practitioner.
Assessment for medicine concordance  
(medicine-taking check)

Contact details *(please print)*
Service user/patient’s name........................................................................................................................................
Male □ Female □ Date of birth *(optional)*.............................................................................................................
Address...........................................................................................................................................................................
....................................................................................................................................................................................Tel no.....................................................................................................................................................................
Name of GP or surgery ........................................................................................................................................................
Pharmacy *(if used regularly)*.........................................................................................................................................

Where is this form being completed?
Patient’s home □ Pharmacy □ Hospital □ Other □ Please specify...........................................................................

1) Medicine arrangements at home
‘Tell me how do you order and collect your repeat prescriptions and medicines?’

Do you remember to order on time?  Usually □ Sometimes □ Never □
Do you remember to collect on time?  Usually □ Sometimes □ Never □

Do problems with ordering/collecting ever cause you to miss any of your medicines?

Usually □ Sometimes □ Never □

What arrangements have you made?  e.g. collected by a friend/relative/carer
....................................................................................................................................................................................

ACTION:
Does the patient need help ordering/collecting prescriptions?  Yes □ No □
If yes, what arrangements could be made?
e.g. synchronise medicines □ Pharmacy collect prescription □ Friend/relative collect □
Other ..................................................................................................................................................................................

2) Patient’s understanding and views about their medicines

Do you know what your medicines are for?  Yes □ No □
Do you understand how to take your medicines?  Yes □ No □
Do you know what to do if you miss a dose/take too much?  Yes □ No □
Would you like more information about your medicines?  Yes □ No □
Do you think your medicines are working for you?  Yes □ No □

Do you regularly take any ‘over the counter’ medications?
If yes, what do you take and how often? ........................................................................................................................

Do you regularly take any ‘homeopathic’ medications?
If yes, what do you take and how often? ........................................................................................................................

Do you have any concerns about taking your medicines?
If yes, what are these concerns? ...........................................................................................................................................
**ACTION: Does the patient need more information about any of their medicines?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Please give details…………………………………………………………………………………………

Referral to their ……………………………… GP [ ] Pharmacist [ ]

with regard to concerns about their medicines and/or side effects

<table>
<thead>
<tr>
<th>3) Patient’s adherence to their medicine regime</th>
</tr>
</thead>
</table>

(Sometimes people take more or less of their medicines, depending on how they feel)

**Do you usually take your medicines as prescribed?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

When might you vary this?…………………………………………………………………………………………

**How often do you forget to take your medicines?**

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
</table>

Do you use a system to help you to remember to take your medicines?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, what system do you use? ………………………………………………………………………………………….

If yes, does this always remind you to take your medicines?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Does anybody help you take your medicines?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, who usually helps you?

A relative [ ] District nursing service [ ] Home care assistant [ ] Other [ ] Please specify…………………………

In what way do they help you? ……………………………………………………………………………………………

**Do you think you need somebody to help you take your medicines?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, ideally, who would you choose to give you this help?………………………………………………………………………………

**What do you do with medicines no longer needed?** ……………………………………………………………………………………………

<table>
<thead>
<tr>
<th>ACTION: Does the patient need:</th>
</tr>
</thead>
</table>

- A reminder chart, or other means of prompting?  
  | Yes | No |

- An assessment for MDS?  
  | Yes | No |

If ‘yes’ a level 2 or level 3 medication review should be undertaken by GP/Pharmacist/[Practice Nurse or District Nurse]

- Referral to domiciliary care services for assistance with administration?  
  | Yes | No |

Any other actions needed?………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………

3
4) Do you have any problems with...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Action needed. e.g. refer for specialist advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening lids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using blister packs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picking up tablets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swallowing tablets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splitting tablets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pouring liquid medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing eye/ear drops</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injecting insulin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other devices <em>e.g. inhalers</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading labels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading and/or understanding English</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding the medicine - taking instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding time of day/week</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date:__________________________**

Assessment done by *(print name)*..........................................................Signature..........................................................

*Job title*: ........................................................................................................

*I am aware that the information contained in this assessment may be shared with other health/social care professionals when appropriate for my care arrangements*

Patient’s signature: .............................................................................

*OR* Carer’s (i.e. family member or other person caring for you) signature & contact details

*(When completed on behalf of user): .................................................................

**Summary of outcomes of this assessment:**

to be completed by a health care professional/social care manager.

Signature: ..........................................................Print name: ..........................................................

Information and advice..........................................................

Specialist advice ..................................................................

Category 1 assistance (self administering but requires help with ordering and collecting prescriptions)... ☐

Category 2 assistance (as above and also needs prompting to take medication) .......................... ☐

Category 3 assistance (requires supervision with self administering or total medication management which may include some direct administration.) ......................................................... ☐

Category 4 assistance (Total medication management which may include some direct administration and invasive procedures) ........................................................................................................... ☐

Copies sent to:  GP ☐  Community Pharmacist ☐  Dom. Care Manager ☐  Others ........................

Suggested review date: .............................................................