**Patient Assessment Tool for Medicines Compliance Support**

This assessment tool should be used when a patient presents with a compliance problem to their prescribed medication. Using this tool will help identify the best intervention for the patient to improve their compliance based on their needs.

All health care professionals in both community and acute settings within Cambridgeshire and Peterborough are advised to use this tool when assessing the most appropriate intervention to help support compliance.

Patients must be assessed to determine the support required to aid medication compliance. This form sets out the person’s actual needs, risks and whether compliance support is required. This form can also be used to determine if a reasonable adjustment is required from the pharmacist and/or the prescriber under the [Equality Act (2010)](http://www.legislation.gov.uk/ukpga/2010/15/contents).

In the first instance, this assessment should be completed **face to face with the patient**. Where this is not possible and to ensure the patient receives the required support, telephone assessments may be undertaken. Following the initial assessment, it is good practice to arrange a follow up telephone review with the patient, approximately one week after starting the compliance intervention.

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| --- | --- |
| **Patient Details** | |
| Name | Enter name |
| Address | Enter address |
| Date of Birth | Enter date of birth |
| NHS Number | Enter NHS number |
| Telephone Number | Enter telephone number |
| GP Practice | Enter GP practice name |
| **Assessors Details** | |
| Name of Assessor | Enter assessor |
| Name of Organisation | Enter organisation |
| Telephone Number | Enter telephone number |
| Occupation/Profession | Enter occupation |
| **Assessment Form** | |
| Is this assessment form being completed with the patient or with the carer/family member/other? | Patient  Carer/family member/other |
| How is this assessment form being completed? | Face to face  Telephone |
| Time taken to complete assessment form (please specify)? | Enter time |
| Date of completion | Enter date |
| **Equality Act** | |
| Does the Equality Act apply to this patient? | Yes  No |
| Does the patient have a long-term health condition as defined by the Equality Act? | Yes  No |
| Is any adjustment for the benefit of the patient (rather than a carer)? | Yes  No |
| **Link to Equality Act (2010):** <http://www.legislation.gov.uk/ukpga/2010/15/contents> | |

**Step 1: Current Medication**

|  |  |
| --- | --- |
| **Current Medication** | |
| Do you administer your own medicines or are they given to you by a carer/family member/other? | Self administration  Carer/family member/other**\*** |
| Total number of medicines prescribed by GP? | Enter number |
| Number of doses taken during the day? | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Morning** | **Lunch** | **Evening** | **Night** | **>5 times a day** | | Enter number | Enter number | Enter number | Enter number | Enter number | |
| **\***This assessment is designed to help patients who are administering their own medicines. If a patient has a carer who administers their medicines, they could be supplied with medicines dispensed in original packs and a Medication Administration Record (MAR) chart. | |

**Step 2: Does the patient have any problems/difficulties with taking their medication?**

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| --- | --- |
| **Taking medicines** | |
| Are you able to swallow all tablets/ capsules? | Yes  No |
| **Manuel dexterity & co-ordination** | |
| Grip medicine bottles? | Yes  No |
| Open and close child resistant lids? | Yes  No |
| Open and close winged lids? | Yes  No |
| Open and close screw lids? | Yes  No |
| Open medicine boxes? | Yes  No |
| Open blister strips? | Yes  No |
| **Eyesight** | |
| Are you able to see your medicines clearly to identify each one? | Yes  No |
| Are you able to read the medication label? | Yes  No |
| If **NO** to questions above, what font size can you read (please refer to Appendix 1)? | If no, enter font size (see appendix 1) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Understanding and complexity** | | | |
| Do you understand the reason for taking each medication? | Yes  No | | |
| Do you know when to take your medication and how many to take? | Yes  No | | |
| Do you understand how to take PRN medication? | Yes  No | | |
| Do you understand how to take variable doses (e.g. Warfarin)? | Yes  No | | |
| **Remembering to order prescriptions** | | | |
| Do you have any problems remembering to order your repeat prescriptions on time? | Yes  No | | |
| **Remembering to take your medicines** | | | |
| Do you remember to take your medication regularly? | Yes  No | | |
|  | Daily | Weekly | Monthly |
| How often do you forget to take your medication? |  |  |  |
| What do you think is the reason you do not always take your medication? | Enter comment | | |

* If the answer to each question is **YES,** it is unlikely the patient requires additional compliance support.
* If the answer to any question is **NO** proceed to **Step 3** for suggested adjustments.

**Step 3: Which adjustments might be appropriate?**

Please find below a list of suggested adjustments to aid compliance problems. This list is not exhaustive.

|  |  |  |  |
| --- | --- | --- | --- |
| **Problem** | **Solution** | **Agreed with patient** | **Comments** |
| **Eyesight** | Provide large print labels |  | Enter comments |
| Provide symbol or colours on each box (e.g. AM = sun) |  |
| Provide Braille labels (if possible) |  |
| Relative/carer administers all medication |  |
| **Manual dexterity and co-ordination** | Provide screw/winged lids |  | Enter comments |
| Provide large bottles/boxes |  |
| Dispense blister packed medicines into bottles (check expiry date, reductions required?) |  |
| Provide halved tablets if possible |  |
| Relative/carer administers all medication |  |

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| --- | --- | --- | --- |
| **Problem** | **Solution** | **Agreed with patient** | **Comments** |
| **Understanding and complexity** | Simplify medication regime |  | Enter comments |
| Conversation with pharmacist to aid understanding |  |
| Medicines Reminder Chart |  |
| MAR Chart |  |
| Relative/carer administers all medication |  |
| **Remembering to order prescriptions** | Electronic repeat dispensing via Pharmacy if appropriate |  | Enter comments |
| Reminder on calendar |  |
| Relative/carer organises repeat prescription ordering |  |
| **Remembering to take medicines/ memory** | Rationalise medicines regime |  | Enter comments |
| Medicines Reminder chart |  |
| Relative/carer administers all medication |  |
| MAR chart |  |
| Smartphone reminders |  |
| TEC team (please refer below for further information) |  |
| **Swallowing** | Recommendations to GP of alternative formulations |  | Enter comments |
| Simplify regime where possible |  |
| **Other local specialised support services** | **Domiciliary medicines management service:**   * Marion Rayner (covers Cambridge City & South Cambridge – 01223 219241 or 07966894044 * Pippa Scrimshaw (covers Isle of Ely & Fens) – 01353 772525 or 07908838059 |  | Enter comments |
| **Technology Enabled Care (TEC) team:**   * Part of Cambridgeshire County Council (county wide service) – 01480 378181 or email at [tec@cambridgeshire.gov.uk](mailto:tec@cambridgeshire.gov.uk)   Please refer to the following [link](https://www.cambridgeshire.gov.uk/residents/adults/staying-independent/equipment-and-technology/technology-enabled-care) for further information. |  | Enter comments |

* If a suitable adjustment can be made, agree with the patient and commence
* If none of the suggested adjustments are suitable for the patient, proceed to **Step 4**

**Step 4: Is a multicompartment compliance aid appropriate (MCA)?**

These are commonly known as **blister packs**, **dossette boxes** or **monitored dosage systems** (MDS).

|  |  |
| --- | --- |
|  | **Please tick** |
| Is all medication suitable for inclusion in an MCA? (Please refer to the following [SPS link](https://www.sps.nhs.uk/articles/usage-of-medicines-in-compliance-aids/) for further information) | Yes  No |
| Does the regime include non-blistered medication e.g. eye drops, creams, liquids, PRN medicines, variable dose medicines (e.g. warfarin)? | Yes  No |
| **If medication is not suitable for inclusion in an MCA and/or if the regime includes non-blistered medication then this patient may be better supported with using original packs of all their medicines alongside an appropriate adjustment.**  **If an MCA is appropriate, please refer to the next question.** | |
| Is the patient/carer/family member able to fill an MCA themselves? | Yes  No |
| If yes, would the patient benefit from purchasing a compliance aid over the counter? | Yes  No |
| **If a pharmacy-filled MCA is to be considered:** | |
| Does the patient understand how to use the MCA? | Yes  No |
| Can the patient select medication from the correct compartment? | Yes  No |
| Can the patient remove medication from the MCA? | Yes  No |
| Have the community pharmacy confirmed they have capacity to provide an MCA for the patient? | Yes  No |
| Has the GP confirmed they are in agreement with this arrangement? | Yes  No |
| Will the patient require delivery of the MCA? | Yes  No |
| Does the MCA need to be provided weekly or monthly? | Weekly  Monthly |

**Step 5: Summary of assessment**

|  |  |
| --- | --- |
| **Outcome of discussion, including any agreed support recommendations:** | |
| Enter outcome | |
| **Assessors Signature** | Enter signature |
| **Date of Assessment** | Enter date |
| **Date of Next Review** | Enter date |

Developed and agreed in collaboration with members from:

* **Cambridge University Hospitals NHS Foundation Trust**
* **North West Anglia NHS Foundation Trust**
* **Cambridgeshire and Peterborough NHS Foundation Trust**
* **Cambridgeshire Community Services NHS Trust**
* **Cambridgeshire and Peterborough Local Pharmaceutical Committee**
* **Local Authority**

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| Instructions, insert a 🗶 in the end column to indicate the smallest font size that can read | | Tick if font read |
| Take ONE tablet each morning | 12 |  |
| Take ONE capsule each morning | 16 |  |
| Take ONE tablet at night | 20 |  |
| Take TWO tablets each morning | 22 |  |
| Take TWO capsules each evening | 24 |  |
| Take ONE tablet twice a day | 28 |  |
| Take TWO capsules daily | 36 |  |
| Take ONE tablet at night | 48 |  |

**Appendix 1: Assessing Font Size**