

Mrs. K is currently on the following regular medication

Calcium + vitamin D3 (500mg/10 microg) x2	Paracetamol 1g x2
Escitalopram 10 mg x1	Perindopril 4 mg x1
Metformin 750 mg x2	Chlordiazepoxide 25 mg x 0,5
Furosemide 40 mg x 2	Trimethoprim 100 mg x1
Glucosamine 400 mg x3	Local estrogen 2 times weekly
Buprenorphine plaster 10microg/h 1 plaster weekly	Macrogol 12g x1
Bisoprolol 5 mg x1	Vitamin D 20 microg x1
Pantoprazole 40 mg x1	

When needed medications:

Paracetamol 1g x 1-2

Glyceryl trinitrate spray

The Drug-Related Problem (DRP) Risk Assessment Tool*Basic Client Data*Name *Mrs. K*

Identity number

Age: *86* yearsGender: male female Does the client live alone? Yes No Does the client have an up-to-date medication card/list? Yes No

Who administers the client's medicines?

Automated dose dispensing + home care practical nurse

Is there anyone who determines whether the client takes his/her medicines?

*Home care practical nurse visits Mrs. K. 3 times a week. For those days the PN does not visit her, she leaves the pouches**Potential Risks for DRPs in Medication Use*

1. Does the client have seven or more prescription medicines in current regular use? (excluding basic creams) Yes No
2. Does the client take 12 or more medicine doses regularly each day (excluding basic creams)? Yes No
Example of counting the doses: Drug 1: 1 tablet 3 times a day = 3 doses, Drug 2: 1 dose 2 times a day = 2 doses, i.e., in total 5 doses a day
3. Is the client currently taking medicines for three or more diseases or symptoms? (including acute diseases) Yes No

Potential Risks for DRPs in Medication Use continued

4. Has the client started a new medicine in the last 4 weeks? (excluding different brands of the same active ingredient) Yes No
5. Does the client use medicines that...
- | | | |
|---|-------------------------------------|-------------------------------------|
| a. relieve pain by reducing inflammation (does not apply to paracetamol)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b. elevate the rate of urination (diuretics)? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| c. are intended to lower the cholesterol level (statins)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d. the physician does not know about? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

6. Does the client use any of the following medicines (please check the ones used)? (the list contains medicines with a narrow therapeutic index, medicines for which regular monitoring would be necessary and medicines that otherwise are problematic for the aged)

Amiodarone	<input type="checkbox"/>	Lithium	<input type="checkbox"/>
Carbamazepine	<input type="checkbox"/>	Methotrexate	<input type="checkbox"/>
Digoxin	<input type="checkbox"/>	Theophylline	<input type="checkbox"/>
Fluoxetine	<input type="checkbox"/>	Warfarin	<input type="checkbox"/>

7. Has the client used over-the-counter (OTC) medicines or vitamin, mineral or herbal products in the past two weeks? State which ones. Yes No

silicon + vitamin C and biotin (for osteoarthritis)

Potential Risks for DRPs in Medication Use continue

8. Has the client had any of the following symptoms in the last 4 weeks? (Please tick below 'yes' if it has been ongoing and add another tick in the right column, if the symptom is a new one = a symptom that had first occurred within the last 4 weeks)

symptom	yes	new	symptom	yes	new	symptom	yes	new
drowsiness			nausea			memory problems	X	
fatigue	X		diarrhea			confusion		
skin rash or itch			constipation	X		visual problems	X	
dizziness	X		dizziness when getting up	X		stiffness		
urination problems			recurrent falls			troubles in walking		
muscle pains			swellings			low blood pressure, systolic under 110 mmHg		

9. Has the client had more than one fall in the past 12 months? Yes No
10. Has the client/relative/visitor noticed any changes in client's condition that could indicate adverse drug reactions related to changes in medicines regimen? Yes No

Characteristics of the Client's Care and Adherence

a) Health, health-care setting and care-taking physician

11. Does the client have three or more chronic diseases? Yes No
12. Has the client been in short term care (e.g., interval care) in hospital, nursing home, sheltered housing, health centre ward or some other institution in the past four weeks? Yes No
13. Does the client have more than one physician involved in his/her care? (e.g., general practitioners, specialists, private practitioners) Yes No

b) Adherence

14. Has the client had troubles in
- a. remembering to take the medicines? Yes No
 - b. following the medicines regimen? Yes No
 - c. knowing what his or her medicines are used for? Yes No
 - d. affording the medicines (i.e., economic problems)? Yes No
 - e. opening the drug bottles or packages? Yes No
 - or managing with medicines related therapeutic devices?
15. Does the client consciously sometimes take medicines differently than prescribed? Yes No
16. Is the client (or his/her caregiver) aware of the client's diseases and their treatments? Yes No

Characteristics of the Client's Care and Adherence Continue

17. Is the client (or his/her caregiver administering the medication) aware of the medicines that the client uses? Yes No
18. Have the client's relatives/proxies expressed their concern about the client's medicine use? Yes No

<i>Recommendations for Actions to Resolve DRPs (several items can be selected if necessary):</i>		
	Yes	No
a) Comprehensive Medication Review	<input type="checkbox"/>	<input type="checkbox"/>
b) Using dose dispensing device	<input type="checkbox"/>	<input type="checkbox"/>
c) Automated dose dispensing	<input type="checkbox"/>	<input type="checkbox"/>
d) Visiting the personal physician	<input type="checkbox"/>	<input type="checkbox"/>
e) Visiting a diabetes or asthma nurse in the health centre or the diabetes or asthma pharmacist in the pharmacy	<input type="checkbox"/>	<input type="checkbox"/>
f) Weekly control visits by a home care nurse	<input type="checkbox"/>	<input type="checkbox"/>
g) Follow-up of the client's condition (repeating the risk test)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Client's permission for possible intervening actions?	<input type="checkbox"/>	<input type="checkbox"/>