QualiCCare *Interprofessional care quality for people with chronic and multiple diseases*

Medication Checklist for the Opti-Q project

Points 1–3 can be completed not only by a medical professional (pharmacist, physician) but also by another healthcare worker such as homecare nurse, pharmacy technician or medical practice assistant or coordinator. The medicinal evaluation, including the recommendations (points 4–6) must be completed by the medical professional responsible.

Name and Job Title of the professional (points 1–3):

.....

Name and Job Title of the professional (points 4–6):

.....

Date: .....

1. Patient details

Patient-ID: ..... *(fill out or stick patient-ID label)*

Last name: ..... First name: ..... Date of Birth: .....

Street, Zip Code, Town:

.....

2. Medicines reconciliation (Brown Bag)

(medical prescriptions, self-medication, nutritional supplements → please enter all)

Systematically compile a list of all medications and preparations that the patient currently takes regularly. The goal is to record and communicate the patient's medical information accurately, comprehensively, and consistently across all care interfaces. Transfer this list to the eMediplan and discuss the individual medications according to the following checklist.

Caution: Do not merely transfer the medicines from the information system but discuss each medicine with the patient before adding it.

The eMediplan can be accessed directly from the electronic information system of the pharmacy or the medical office, or electronically via Pharmavista or Compendium by entering your SwissRx login.

3. Questions Regarding Current Medication[1]

Take the updated medication plan and for each medication, discuss the questions in the list below to uncover any medication difficulties. Shaded areas require further clarification by the pharmacist or the medical professional responsible.

Usage, Effectiveness:

A. Do you know why you take the medications listed in the eMediplan?

☐ Yes ☐ Partially ☐ No

If "partially" or "no": Which medication do you not know? (Please explain to the patient)

B. Do you know how to take and store your medications (application, dosage, maximum daily dosage, dosage spacing, application method, influence of food, handling, storage)?

☐ Yes ☐ Partially ☐ No

If "partially" or "no": Which medication do you not know? (Please explain to the patient)

C. Do you feel that the medications are effective for you?

☐ Yes ☐ Partially ☐ No

If "partially" or "no": which one(s)? Please explain the mechanism of action of the medication(s) and the fact that often the side effects are more noticeable.

Treatment Compliance:

D. Do you have any difficulty taking your medications or do you sometimes forget to take any?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": which one(s)? Please note possible solutions in the "pharmaceutical recommendations" section.

E. Do you tolerate all your medications well?

☐ Yes ☐ Partially ☐ No

If "partially" or "no": How do you manage this? Please note possible solutions in the "pharmaceutical recommendations" section.

[1] *Questions adapted from PharmaWiki https://www.pharmawiki.ch/wiki/index.php?wiki=Medikationsanalyse*

4. Pharmaceutical evaluation of the medication (by a medical professional)

Side effects and risks:

A. Are there any risks and side effects due to the medication?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": Which risks/side effects and with which medication? Please note possible solutions in the "pharmaceutical recommendations" section.

B. Is there a suspected medication overuse?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": Fill out the questionnaire to evaluate a suspected drug addiction (7 questions).

C. Are medication-food interactions to be expected?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": Which medications are involved? Please note possible solutions in the "pharmaceutical recommendations" section.

D. Are there any contraindications for one or multiple medication(s)? To answer this question, various tools in your pharmacy or medical office software can be useful.

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": Which medications are involved? Please note possible solutions in the "pharmaceutical recommendations" section.

E. Are there any alternative medications that may be better tolerated?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": which ones? Please note possible solutions in the "pharmaceutical recommendations" section.

Substitution:

F. Is it possible to substitute any medications with a generic or biosimilar?

☐ Yes ☐ Partially ☐ No

If "yes" or "partially": which one(s)? Please note possible solutions in the "pharmaceutical recommendations" section.

5. Medical Background

Please take note of the patient's medical background based on the facts recorded in the care passport.

☐ I have read the care passport and am aware of the diagnoses, problems, treatment plan and goals of the patient.

A. From a pharmaceutical perspective and considering the patient's medical background as well his / her goals, is the use of all medications appropriate?

☐ Yes ☐ Partially ☐ No

If "partially" or "no": Please note possible solutions in the "pharmaceutical recommendations" section.

6. Pharmaceutical Recommendations

Based on the answers to the above questions, please write your pharmaceutical recommendations regarding possible alternatives, simplifications or changes to the medication in the table on the next page to be discussed with the patient's general practitioner (GP). The **consensus between the GP and the pharmacist** *is then communicated to all other professionals on the patient's healthcare team by entering the information into the care passport. Should the GP perform the pharmaceutical evaluation and recommendation themselves, the here mentioned interprofessional exchange regarding the medication is omitted.*

The pharmaceutical recommendations can either be directly edited in the care passport or printed out and enclosed in the care passport. Please also include an updated eMediplan with the care passport.

Patient consent statement:

I consent to the pharmaceutical recommendations being sent to my GP.

Signature of the patient:

.....

Signature of the medical professional:

Name Signature

....

Duration of the evaluation by a medical professional (points 4 to 6): .....

Pharmaceutical Recommendations

Patient name / First name: Date of Birth:

Medication	Medication-related problem	Pharmaceutical recommendation

Comments: