Self-Medication Assessment Tool

Instructions for Tester

(refer to training modules and slides for more detailed instructions)

Section 1: Demographics should be filled out using the patient's chart before the interview.

Section 2: Scoring Functional & Cognitive Status should be filled out using the kit provided with this testing tool.

- The category "EASE" is checked off when the patient answers the question or does the task relatively quickly and without error.
    - e.g. patient tries the cap, realizes it won't flip open, reads the instructions on the lid, and then opens the bottle with no further problem.
    - e.g. the patient puts all the medication correctly into the dosette, or discovers error and corrects it without any prompting from tester.

- The category "DIFFICULTY" is checked off when the patient makes one or more errors, or needs prompting/cueing from the tester to carry out the task.
    - e.g., the patient needs to be told to read the instructions on the bottle cap.
    - e.g., the patient makes one or more errors and needs to be asked to check for errors, or needs to be given direction to complete the task.

- The category "UNABLE" is checked off when the patient is unable to carry out the task or answer the question, even when prompted or cued by the tester.

- All questions prefaced with "F" are for the functional scale, and all questions prefaced with "C" are for the cognitive scale. Sum the scores across all questions for both of the scales: UNABLE = 0, DIFFICULTY = 1, EASE = 2. (Exception: In questions F10 and F11, EASE = 0.4 and UNABLE = 0 for each individual colour)

Section 3: Recall, Self-reported Adherence and Purposeful Nonadherence

The patient's medication adherence will be assessed using their *Reference Drug List(RDL)* which is defined that list of medications that the patient was expected to be taking regularly prior to admission to hospital or another healthcare facility (eg. Outpatient clinic). The list can be obtained from a verified Best Possible Medication History. The list is transcribed into the reference drug list section of the SMAT form for Recall, Self-reported Adherence and Purposeful Nonadherence

The steps for assessing patient medication Recall are as follows:

- Ask the patient to recall any information that he/she can about these medications
    - The name of the drug
    - The indication for taking the drug i.e. "What do you use it for?"
    - The dose frequency i.e. "the number of tablets/capsules that you take each day and the times that you take them"
    - A description of the drug (colour, shape, dosage form or strength)
- The patient is not to be interrupted during the recall phase

- The assessor records all of the "able" responses as they are recited by the patient
- The assessor can cue the patient to complete categories that the patient did not recall initially
    - For example, the patient has recalled taking a pink blood pressure pill once a day; the assessor can then ask if the patient is able to recall the drug name and the dose frequency
- The patient is given a score of U = unable when not able to respond correctly, even after prompting or cueing and a score of A = able for all correct responses

The steps for completing the Self-reported Adherence section are:

- For each medication on the Reference Drug List, the patient is asked:
    - Did you take it every day or less often?
    - How much did you take each time?
    - How many times per day did you take it?
    - At what times did you take it?
- The assessor can cue the patient by using the medication name, the indication or the medication description
- For patients who have very limited recall or knowledge of their medication regimen, it will be difficult for them to complete this scale
    - The general question, "Did you take it every day or less often?" can be asked
    - The patient is scored as U=unable if not able to respond to the more specific questions about timing and frequency
    - The patient is scored as A=Able for each response to each question for each medication
    - Where patients have provided "able" responses for "dose frequency" for medications in the Recall section, a score of "able" can be assigned for the same questions in the Self-reported adherence section

The steps for completing the Purposeful Non-adherence section are:

- The Reference Drug List is used as a comparator
- For each medication on the Reference Drug List, the patient is asked:
    - "Did this medication ever bother you in any way?"
    - "In your opinion, is this medication helping you?"
- A score of 0 to 3 is assigned to each medication using the definitions on the assessment form
- To identify intentional decisions to stop a medication, the patient is given a brief explanation followed by a question:
    - "Sometimes, people decide that it is best for them not to take a medication they've been prescribed."
    - "Did you ever decide not to take this medication? If so, why?"
- Where the patient has responded in the affirmative, the following question is asked:
    - "How often do you think you've decided not to take this medication?"
    - A score of 0 to 4 is assigned to each medication using the definitions on the assessment form

Scoring Record: Self-Medication Assessment Tool

Scoring for Section 3:

(0 = Unable, 1 = Difficulty, 2 = Ease)	
Sum "F" (Functional) questions:	
Sum "C" (Cognitive) questions:	

Scoring for Section 4:

Patient Recall Score	
Max recall score (# of reference drugs x 4):	
Task score (count of "able" responses):	
Recall score (%) [(task score / max score) x 100]:	

Self-Reported Adherence Score	
Max adherence score (# of reference drugs x 4):	
Task score (count of "able" responses):	
Adherence score (%) [(task score / max score) x 100]:	

Purposeful Non-Adherence Score	
Sum of ranks for Question #1:	
Sum of ranks for Question #2:	
Sum of ranks for Question #4:	
Sum total of ranks for Questions #1, #2, and #4:	
Purposeful Non-Adherence Score (%) [10 * (sum total of ranks/ # meds)]	

Scoring Summary

Functional (X / 28):	
Cognitive (X / 44):	
Medication aid use:	
Recall score (%):	
Self-reported adherence (%):	
Purposeful non-adherence (%):	

Suggested Interpretation of Scores and Recommendations:

No Supervision

- SMAT Scores
  - High Cognitive and Functional scores (90% or greater)
  - Relatively high Recall score (70% or greater)
  - Low Purposeful Non-adherence score (10% or less)
- No Supervision means:
  - Patient likely does not require assistance from family/caregiver
  - Use of compliance aids is optional
  - Detailed medication list or calendar is helpful

Minimal Supervision

- SMAT Scores
  - High Functional score (90% or greater)
  - Relatively high Cognitive score (80% or greater)
  - Low Recall score of 50% to 70% **OR**
  - Purposeful Non-adherence Score of 12% to approximately 15%

- Minimal Supervision means:
    - Family member or caregiver to check adherence
    - Family member or caregiver to assist with certain routes of administration (eg. Metered dose inhalers, injections)

Moderate Supervision

- SMAT scores
    - Moderate Functional score (85% to 89%)
    - Moderate Cognitive score (70% to 80%)
    - Low Recall score (50% to 70%) **OR**
    - High Purposeful Non-adherence score (approx. 15% or higher)

- Moderate supervision means:
    - Enrollment in a structured Self-medication Program in the hospital may be useful
    - A simplified medication regimen is beneficial

Full supervision

- SMAT Scores
    - Low Functional score (approx. 75% or less)
    - Low Cognitive score (approx. 55% or less)
    - Very low Recall score (approx. 40% or less**)** **OR**
    - High Purposeful Non-adherence score (approx. 18% or higher)
- Full supervision means:
    - Home environment – a family member or caregiver fills a weekly pill organizer (dosette) or pharmacist prepared compliance packaging such as blister packs is available;
    - Supervision is available in the home for all medication administration times to ensure that the medications are taken by the patient or to administer the medications to the patient
    - Patients in this category may require further assessment by a Geriatrician
    - Caregivers should receive a detailed medication administration calendar that includes medication names/strengths, indications, route of administration, administration times

Documentation of Recommendations:

(A) Supervision:_____

(B) Compliance Aids:_____

(C) Changes in Drug Therapy:_____

(D) Comments:_____

Pharmacist: Date: