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Title Page - Patient Education and Counselling

Development of a tool to support person-centred medicine-focused consultations with stroke survivors

Daniel DaCosta, Linda J Dodds and Sarah A Corlett¹

Medway School of Pharmacy, Universities of Kent and Greenwich at Medway, Chatham Maritime, Kent. ME4 4TB, United Kingdom

¹: Corresponding author, e-mail address S.A.Corlett@kent.ac.uk

Abstract

Objective

To develop a tool to support medicine-focused person-centred consultations between community pharmacists and stroke survivors.

Method

Semi-structured interviews with 15 stroke survivors and 16 community pharmacists were conducted. Thematic analysis of the data was performed and emerging themes examined to determine their relevance to the principles of delivering person-centred care. Findings were used to generate a framework from which a consultation tool was created. Face validity and the feasibility of using the tool in practice were explored with participating pharmacists.

Results

Three major themes were identified; personal, process and environmental factors. A tool, in two parts, was developed, A 'Getting to know me' form which would help the pharmacist to appreciate the individual needs of the stroke survivor and a consultation guide to facilitate the consultation process. Pharmacists considered that both were useful and would support a person-centred medicine-focussed consultation.

Conclusion

A consultation tool, reflecting the needs of stroke survivors, has been developed and is feasible for use within community pharmacy practice.

Practice Implications

Pharmacists must recognise the individual needs of stroke survivors to ensure that they provide consultations which are truly person-centred. The tool developed could support medicine-related consultations with patients with other long term conditions.

Key words

Consultation tools; consultation skills; Validity; person-centred care; medicine support; stroke

1. Introduction

Stroke has reached epidemic proportions. It has been estimated that 1 in 6 people worldwide will suffer a stroke in their lifetime and that each year around 15 million people worldwide suffer a stroke, over 6 million die and 5 million are left with a permanent disability.¹ Surviving individuals then have a 30-43% chance of a recurrent stroke in the next five years.² This risk has been calculated to be reduced by 80% if secondary preventative medicines (usually a minimum of an antiplatelet, statin and antihypertensives), lifestyle and diet changes are adhered to.³ The World Health Organisation have report that the benefit of improving adherence to existing medicines, for those with long-term conditions, may have a greater impact on their health than any future developments in medical treatments emphasising the importance of better medicine management.⁴

1.1 Adherence to secondary prevention post-stroke

Studies of adherence to secondary preventative medicines post-stroke indicate that persistence to medicines declines rapidly within the first two years.⁵⁻⁷ Longer-term adherence post-stroke is unknown. Research has indicated that the reasons for nonadherence in this patient population are multifactorial and individualised and include younger age, concerns about medications, reduced cognitive function, low perceived benefits of medication and practical barriers.⁸⁻¹⁰ More than half of the stroke survivors in a recent study reported that they needed help taking their medication and 1 in 10 had unmet medicines support needs.¹¹ These findings support the need for a person-centred approach to medicines support.¹²

1.2 Adopting a person-centred approach

Although there is no single accepted definition of person-centred care, a comprehensive systematic review of the literature identified eight key principles.¹³ These relate to getting to know the individual, taking a holistic approach to their care, seeing the patient as the expert about their health, recognising autonomy and sharing decisions about care, ensuring that services are flexible to individuals' need and easy to navigate, striving for continuity of services, ensuring that the physical, cultural and psycho social environment is conducive to delivering care, and having well trained, supportive staff. The positive impact of person-centred care has been clearly demonstrated in terms of patient satisfaction and health outcomes¹⁴⁻²⁰, but its translation into practice has been mixed, and the associated challenges to its adoption acknowledged.^{13,21-35} Concerns have been raised that more traditional, less patient inclusive approaches to care have prevailed in stroke rehabilitation.^{30,36} A search and review of the literature confirmed that there were no suitable tools to support pharmacists' delivery of person-centred medicine-focused discussions with stroke survivors³⁷ and that generic consultation tools encouraged didactic conversations which may not address the holistic needs of these patients.^{10,29-52}

1.3 Current medicines support post-stroke

Medicines support post-stroke is frequently limited to the provision of generic information, often at hospital discharge. Evaluated initiatives to support continued adherence in this patient group have

been primarily hospital-based and have focused on the provision of information and motivational interviewing in the first few months post-stroke. Most demonstrated modest short-term impact on adherence and clinical markers but did not address the long-term impact.⁵³⁻⁵⁷ The majority of stroke survivors are discharged from specialist care after a few months and are then cared for by a general practitioner with their medicines supplied by a community pharmacist.

The current stroke pathway in England does not integrate medicines support into rehabilitation, yet stroke survivors face significant challenges when taking multiple medicines. Over half suffer physical (swallowing, dexterity, mobility) and cognitive (speech, memory, fatigue) deficits which can significantly affect their activities of daily living.⁵⁸ Community pharmacists are well placed to provide medicines support post-discharge as they dispense medicines on a regular basis, usually monthly, and have the knowledge and skills required. For example, community pharmacists could ensure that stroke survivors receive an appropriate formulation of their medicine, or could help to establish individualised medicine taking routines that fit with the lifestyle and preferences of the stroke survivor.

1.4 Research aim

To develop a tool to support the optimal delivery of a person-centred medicine-focused consultation between stroke survivors (SS) and community pharmacists (CP).

Specific objectives were:

- To explore SS experiences of receiving medicines support and their expectations and perceived need for such services
- To explore CP understanding of what constitutes a person-centred consultation and their perceptions of how to deliver such consultations in general, and specifically to a SS
- To use the findings to develop a tool to support the optimisation of person-centred medicine consultations between SS and CP.

1.5 Ethics

Approval was gained from the Medway School of Pharmacy Ethics Committee June 2014 (REF04241).

2. Methods

2.1 Interviews

2.1.1 Recruitment

Inclusion and exclusion criteria for participants (SS and CP) are listed in Table 1.

SS were recruited via three sources: Stroke Association service user groups; Age UK day centres; snowballing (to include independent recruits). Appropriate approval was obtained before approaching the user groups and day centres. After an expression of interest from a potential interviewee the researcher conducted a face to face meeting to offer a letter of invitation, information leaflet, establish eligibility for inclusion in the study, and answer any questions. This contact also enabled the researcher

to identify any specific requirements the SS may need during the research interview. All materials for SS used the Flesch-Kincaid Grade Level⁵⁹ as recommended by the Stroke Association to ensure text readability

CP were randomly selected in batches of ten from a publically available list of NHS community pharmacies in Kent (excluding one large national chain due to the company's governance requirements). A letter of invitation which included information about the study was followed up a week later by a telephone call from the researcher to confirm eligibility for inclusion, and seek agreement to an interview.

Written consent was obtained prior to interview for all participants.

2.2 Instrumentation

Interview schedules were developed which reflected the aims and objectives of the research for each participant group. These were piloted with selected volunteers outside of the study.

2.3 Data collection

2.3.1 Stroke Survivors. Interviews were conducted at a time and place agreed with the participant a minimum of 72 hours following the first meeting. Formal consent was obtained, then data were collected on demographics and the participant's medicines were photographed. The interviews were audio recorded. The interviews were not time limited and were guided by the needs of the participant. Family or a carer were invited to be present if the participant wished and their consent was also obtained.

2.3.2 Community Pharmacists. Interviews were conducted in each pharmacist's place of work at a time which suited the participant and audio recorded.

The researcher recorded a personal reflection and field notes on each interview which included a description of the environment within which the interview had taken place. A pen portrait of each participant was created. All interviews were transcribed and recruitment stopped when thematic saturation of the data had been achieved.

2.4 Data analysis

Analysis of the data was guided by the stages of interpretative interactionism.⁶⁰⁻⁶² Interpretative interactionism specifically seeks to understand the experience of participants during life changing moments and offers a person-centred approach by placing participants at the heart of the research process to support the development of practice. Using NVivo 10 software data were coded and themes generated separately for SS and CPs. Overarching themes arising from the interviews were then mapped to the principles of person-centred care.¹³

2.5 Face validity testing of the tool

The finalised tool, which included the consultation guide and accompanying 'Getting to know me' form, were sent to all the CPs who had been interviewed together with a short form which asked for their views on its content and potential use in practice. The responses were analysed under the following headings: face validity; design, value, use, and other.

3. Results

3.1 Stroke Survivor interviews

Twenty-two SS were screened for eligibility of which fifteen were interviewed . Of these, eight were recruited via the Stroke Association, four via Age UK and three were recruited independently through snowballing. Of the seven who were ineligible, two had suffered a haemorrhagic stroke and the remainder had not had a discussion with their community pharmacist within the last 12 months. The demographics for the interviewed SS can be seen in Table 2.

All participants reported physical difficulties which restricted basic activities of daily living and the majority reported cognitive problems and felt that the stroke had negatively impacted on their mental and psychological health.

Participants had varying levels of knowledge about their medicines. Two thirds of the SS had unmet information needs in terms of the medicines they had been prescribed post-stroke, while carers also expressed a need for more information.

All participants expressed positive beliefs and attitudes towards their medicines, recognising that continued use was important to prevent a further stroke, but many expressed that the quantity required to be taken and the need to take them long-term was a burden to them. Although coping strategies for taking medicines were described by some, and all reported taking their medicines as prescribed, physical and cognitive problems were observed that could potentially compromise medicine-taking behaviours in a number of participants. The researcher observed physical problems that prevented patients accessing doses easily and recorded participants describing how cognitive difficulties sometimes led to missed doses. A number of the problems identified were amenable to professional help, such as altering the dosage form or packaging, but the SS had not considered asking for help or had difficulties accessing their pharmacy without support due to the impact of their stroke.

Relationships between the SS and CP were explored and found to be primarily around supply of medicines. Most SS stated they did not know their CP as a person and that the CP did not know them. Some were unsure who was the pharmacist in the pharmacy they used as they saw only the counter staff, others had their medicines delivered as they were unable to access the pharmacy because of their disabilities. A number reported that they felt comfortable asking their pharmacists for advice related to minor ailments, but looked to their GP for information about their prescribed medicines. There was a general lack of awareness of the services a pharmacist could offer. Several

had however set in place coping strategies to manage their medicines, sometimes with the help of a family member, carer or health professional.

Around half of the SS interviewed had experienced a sit-down consultation with a pharmacist in a private room, but their reported experiences were mixed. Although some rated the experience positively and of benefit to them, others offered more negative comments, saying the pharmacists had not addressed their individual needs, or had spoken too quickly for them to understand. Concerns were also expressed by some about how their carer had been involved. For most SS, their general practitioner was seen as the first port of call for medicine-related queries and the pharmacist was perceived as primarily the supplier of medicines, with problems associated with the efficient supply of medicines leading to loss of trust in the pharmacy service. Data analysis enabled a framework to be generated under three key themes: personal factors, process factors and environmental factors (Figure 1).

3.2 Community Pharmacist (CP) Interviews

Twenty-nine pharmacists were invited to participate. Sixteen agreed, were screened for eligibility and visited at their place of work. Of the thirteen who did not participate two were not contactable despite repeated attempts, nine stated they were too busy, one that management permission was needed and one that no regular pharmacist was working in the pharmacy. Eight interviewees were female Six has been qualified for less than 10 years, the remainder for longer than 10 years. Four worked in independent pharmacies and the remainder in multiples.

Although all CPs demonstrated knowledge and understanding of person-centred care, and attitudes towards this approach were universally positive, the ensuing discussions frequently indicated that this was not practice they consistently provided during their day-to-day work in the pharmacy. The CPs acknowledged the need to know patients as individuals and most participants described knowing the majority of those who regularly used their pharmacy. They considered that their patients also knew them, albeit solely as a professional. It was recognised that patients who had medicines delivered to them as a result of their lack of mobility would not know them, as domiciliary consultations were rare, requiring special permission from local health managers. When asked specifically about consultations with SS most of the CPs interviewed were unable to recall an interview with a SS and some had a limited understanding of the many sequelae of a stroke which may need to be taken into account in order to undertake a successful consultation.

The difficulties of providing person-centred care were highlighted by most CPs. Lack of time in a busy working environment was the key barrier to developing relationships with patients with cognitive or speech difficulties. The field notes of the researcher also noted the environmental difficulties that would compromise a discussion with a SS, including noise and small or crowded consultation rooms that would have difficulty accommodating a patient in a wheelchair and their carer. Most CPs were

very supportive of further guidance that could help them to deliver person-centred care to SSs, but noted that it should be concise and easy to refer to when needed to guide a consultation.

The themes emerging from the interviews were summarised in a framework under the same three headings as used for the SS interviews (Figure 2).

3.3 Development of the consultation tool

The two frameworks developed from the interviews were used (Figures 1 and 2), together with findings from a literature review on this topic³⁷, to inform the development of a tool (Figure 3) that comprised consultation guidance and an accompanying 'Getting to know me' form.

The 'Getting to know me' form reflected the importance accorded to getting to know the person as an individual.¹³ Two versions were created, a written and pictorial presentation. The need for an alternate aphasia friendly form was recognised as crucial by both SS, as a result of their diverse and individualised needs, and also by the pharmacists. The consultation guide comprised a section entitled 'Starting out' which covered issues to consider before initiating the consultation. The second section 'Getting the best from the consultation' identified a number of issues to help optimise the consultation process.

3.4 Face validity testing

Fourteen of the sixteen pharmacists who had participated in the interviews were contacted. The remaining two had left their place of work. Eleven responded. All respondents considered the tool was useful for its intended purpose, considering that it would support person-centred care. Although all respondents recognised its value and reported they were willing to use it in practice, two raised the time required as a barrier to its use.

4. Discussion and Conclusion

4.1 Discussion

This research has reinforced the need for improved medicines support for stroke survivors and highlighted how person-centred medicines consultations between SS and health care professionals (HCPs), particularly CPs could be improved. Three areas were identified as key to a successful person-centred consultation about medicines with SS: the need to develop a personal relationship between the SS and CP/ HCP (personal factors); the need to adapt the consultation to promote SS understanding and ability where cognitive or physical problems may limit these (process factors); and the need to get the environment for the consultation right (environment factors). These were incorporated into a tool comprising two forms which could be used to support the practitioner initiating the consultation. The tools will help to guard against the tendency for didactic education and focus the consultation on the specific needs of the SS thus promoting person-centred care.

Personal factors. The importance of having a personal relationship with health care providers who understand their problems and respond to their needs was clearly articulated by SS. They expected health care professionals to know they had had a stroke and were also happy to be asked whether they had had a stroke and how it affected them, but did not wish to repeat this information at every encounter. Yet this was not their experience and the pharmacists interviewed struggled to remember a consultation with a SS. The benefits to both pharmacists and their patients of developing a relationship have been identified in earlier studies.⁶³⁻⁶⁵ However, community pharmacists and other health care professionals or carers involved in rehabilitation and support post-stroke may not have ready access to clinical notes. This means that the healthcare provider will need to ask the SS directly about their personal circumstances. This was the rationale behind the development of a 'Getting to know me' form that could be completed by the SS or a carer.

The importance of the efficient dispensing of medicines was mentioned by many SS and has been demonstrated to be more important than a personal relationship between patients and pharmacists in some studies^{66,67}, with supply problems leading to lack of confidence or trust in the pharmacist. In this study, as in other studies^{68,69}, the SS interviewed predominantly saw pharmacists as a supplier of medicines and their doctor as the supplier of information and support. Many studies over the years have highlighted the lack of general public awareness of the role pharmacists as experts in medicines can play in medicines support and have emphasised the need to develop and promote better awareness of pharmacy services.^{64,70,71}

Although around half of the SS interviewed had experienced a private conversation with a pharmacist, for some these were not useful experiences. This has been reported in earlier studies. Latif noted that UK community pharmacists met pharmacist professional objectives rather than being patient-centred when undertaking consultations²⁹, while Murad found a biomedical model approach was significantly more prevalent than a patient-centred focus in patient-pharmacist interactions.⁷² When pharmacists were asked themselves how they identified professionally, 'scientist' emerged as the strongest identity.^{63,73} Elvey et al. reported UK pharmacists as scoring high on academic ability but relatively low in terms of social skills⁶³, while Salter described pharmacists as being anxious in relation to patient-pharmacist communication.⁷⁴ Authors world-wide have identified personality factors and pharmacy culture issues which impact negatively on the provision of person-centred care by pharmacists^{63,73-81} although it is suggested that recently qualified pharmacists are more prepared for, and open to, delivering this extended pharmacy role.^{76,77}

Process factors. Many of the community pharmacists interviewed were not aware of the diverse sequelae of a stroke in terms of cognitive disabilities such as aphasia, difficulty following conversations, or in remembering information. The interviews with SS highlighted the unmet medicine-support needs identified in earlier studies^{10,11} but also indicated that this patient group do not always recognise that the medicines-related problems they experience could be resolved, and

their information needs met. This means efforts must be made to establish exactly what problems a patient may have, and respond to them appropriately in the course of the consultation.

Environmental factors. The importance of a suitable environment which can provide a confidential person-centred consultation for SS who may have mobility issues or who may need a carer to attend the consultation was raised by many SS. There was considerable variation in the quality of consultation rooms provided by the pharmacies interviewed for this study. In the pharmacies visited the researcher noted distractions such as clutter or background noise that could impact negatively on a consultation in this patient group. Guidance on factors which support a consultation with a person with disabilities arising from a stroke have been published.⁸²⁻⁸⁵ Although concerns were expressed about pharmacy consultation spaces in 2009, a study in 2013 noted that most had improved and 90% were assessed as being fit for purpose.^{86,87}

4.2 Strengths and Limitations

Recruitment was restricted to participants within the UK county of Kent, and excluded pharmacists working for one national chain of pharmacies. However, a diverse sample of pharmacists were recruited, of varying age, ethnicity, gender, employment status and work-experience. Stroke survivors were white British and therefore the experiences of other ethnicities were not explored. However, the stroke survivors did exhibit a broad range of disabilities and varying lengths of time post-stroke. Only single interviews were conducted and as a result the data reflects only the experience of participants at one point in time. Consultations between stroke survivors and community pharmacists were not actually observed, and therefore the data may have been limited by participants' ability to accurately recall and articulate their experiences and perceptions. All of the pharmacist interviews were conducted in the Pharmacy with the majority being held in the consultation room. This is the same environment within which pharmacists would conduct medicine-related consultations with stroke survivors.

4.3 Conclusion

A consultation tool in two parts has been developed to support person-centred medicines consultations between stroke survivors and community pharmacists. The design reflected the needs and preferences of stroke survivors and the current working practice of community pharmacists based in the UK. This novel tool now needs to be fully evaluated to determine its feasibility for use in practice and the impact on patient care.

4.4 Practice implications

This research has a number of implications for community pharmacy practice but also much wider implications for the long-term care of stroke survivors. The methodology described could also help tailor medicines support for other patient groups who face difficulties in adhering long-term to their required medicines, either because of the nature of their disease or the complexity of the medicines regime.

Pharmacists supporting stroke survivors must make more effort to identify stroke survivors in their care. This will require them, and perhaps their supporting staff, to be more proactive in asking whether patients on certain combinations of medicines likely to indicate a stroke whether they are stroke survivors. As SS often have limited awareness of the services that pharmacists can provide every opportunity to raise awareness of these should be made, for example by displaying posters advertising the medicine consultation service in the pharmacy. Pharmacists can then use the tool to help optimise discussions with the SS; however, there may for some be a need to also extend their knowledge around the sequelae of stroke and managing consultations with patients with aphasia or other cognitive difficulties. Pharmacists also need to be more aware of the environment in which they conduct consultations, and must ensure it is conducive to the needs of SS. A proportion of SS are unable to visit the pharmacy in person. Telephone conversations may not always be possible for this patient group. Pharmacists will need to consider how these patients can be supported, perhaps by having discussions with health care commissioners about the provision of domiciliary services.

Stroke survivors need to be made more aware of the services available from pharmacists to support them in their medicine taking. This means that all members of the secondary care stroke team, and those providing long-term care in general practice also need to be aware of pharmacy services and signpost patients who appear to require medicines support. Ideally, formal referral processes need to be set in place, to ensure continuity of care within the stroke pathway, and which allow the pharmacist to access the medical notes to support them in their consultations and share their advice and actions with others caring for the patient.

Finally, the format of this tool makes it usable by other health care professionals who may wish to provide medicines support. The methodology described could also be easily adapted to develop bespoke tools to support patients with other long-term conditions leading to polypharmacy.

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Figure and Table legends – (no colour is required)

Table 1: Participant Inclusion and Exclusion Criteria

Table 2: Stroke Survivor Demographics

Table 3: Community Pharmacist Demographics

Figure 1: Stroke Survivor Framework

Figure 2: Community Pharmacist Framework

Figure 3: Consultation Tool

Table 1: Participant Inclusion and Exclusion Criteria

	Inclusion criteria	Exclusion criteria
Stroke Survivors	<ul style="list-style-type: none"> • Possesses sufficient capacity to participate: ref Mental Capacity Act (Office of the Public Guardian 2005) • Has experienced an ischaemic stroke • Has been prescribed medication since stroke • 18 years or older at the time of the study • Able to understand and communicate in English (i.e. verbal/reading) • Lives within the county of Kent (UK) or surrounding areas • Has access to and uses a regular community pharmacy • Has had a discussion with a community pharmacist within the last twelve months 	<ul style="list-style-type: none"> • Not in possession of sufficient capacity to participate: ref Mental Capacity Act (Office of the Public Guardian 2005) • Has not experienced stroke or stroke not of an Ischaemic nature • Has not been prescribed medication since stroke • Under 18 years of age • Not able to understand and communicate in English (i.e. verbal/reading) • Lives outside of the county of Kent (UK) or surrounding area • Does not have access to or use a regular community pharmacy • Has not had a discussion with a community pharmacist in the last twelve months
Community Pharmacists	<ul style="list-style-type: none"> • In possession of a UK recognised pharmacy qualification/registration • Is accredited to provide MUR/NMS • Is either a full time or part time pharmacist at one (regular) pharmacy • Has undertaken a patient consultation (i.e. MUR/NMS) at a community pharmacy within the last month • Is currently working within the county of Kent (UK) 	<ul style="list-style-type: none"> • Does not hold a UK recognised pharmacy qualification/registration at the time of the study • Is not accredited to provide MUR/NMS • Is not either a full time or part time pharmacist at one (regular) pharmacy • Has not undertaken patient consultation (i.e. MUR/NMS) at a community pharmacy within the last month • Is not currently working within the county of Kent (UK)

Table 2: Stroke Survivor Demographics

#	Sex	Age	Interview duration (minutes)	Time since	Self-reported disability via modified Rankin scale (mRs)	Live in support (present at interview)
1	F	73	39	6	Slight (2)	Spouse
2	M	66	25	5	Moderate (3)	Spouse
3	M	52	46	3	Moderately severe (4)	Spouse (at interview)
4	F	88	35	2	Moderately severe (4)	Sheltered housing staff
5	M	65	39	1	Moderately severe (4)	Spouse (at interview)
6	F	67	34	11	Moderate (3)	Child
7	M	65	75	9	Moderately severe (4)	Spouse (at interview)
8	F	91	24	2	Moderately severe (4)	None – lives alone
9	M	58	83	6	Moderately severe (4)	Spouse
10	M	70	45	6	Moderately severe (4)	Spouse
11	M	65	37	16	Moderately severe (4)	Spouse
12	F	48	36	10	Moderate (3)	Spouse
13	F	86	31	9	Moderately severe (4)	None – lives alone
14	F	80	38	3	Slight (mRs 2)	Child
15	F	68	59	6	Moderate (mRs 3)	Sheltered housing staff

Table 3: Community Pharmacist Demographics

#	Pharmacist characteristics: Gender/ Time qualified/Employment status	Type of Pharmacy: Independent (I) Small multiple (S), Large multiple (L)	Interview Location in Pharmacy	Interview Duration
1	Male/10-20 years/ Manager	S	Consultation room	37 mins
2	Male/10-20 years/Owner	I	Pharmacy office	23 mins
3	Female/20> years/ Manager	L (supermarket)	Consultation room	35 mins
4	Female/20> years/Regular locum	I	Consultation room	39 mins
5	Male/<10 years/Manager	L (supermarket)	Consultation room	32 mins
6	Male/20> years/ Manager		Consultation room	30 mins
7	Female/<10 years/ Manager	L	Consultation room	37 mins
8	Female/ <10 years/ Owner	I	Pharmacy office	27 mins
9	Female/ <10 years/ Manager	S	Consultation room	66 mins
10	Female/ 20> years/ Manager	I	Pharmacy office	53 mins
11	Female/20> years/ Locum		Pharmacy office	51 mins
12	Male/20> years/Manager	L (supermarket)	Pharmacy office	35 mins
13	Male/20> years/ Manager		Consultation room	46 mins
14	Female/10-20 years/Manager	L (supermarket)	Consultation room	37 mins
15	Male/ <10 years/ Manager	S	Consultation room	37 mins
16	Male/ <10 years/Manager	L	Consultation room	41 mins

Figure 1: Stroke Survivor Framework

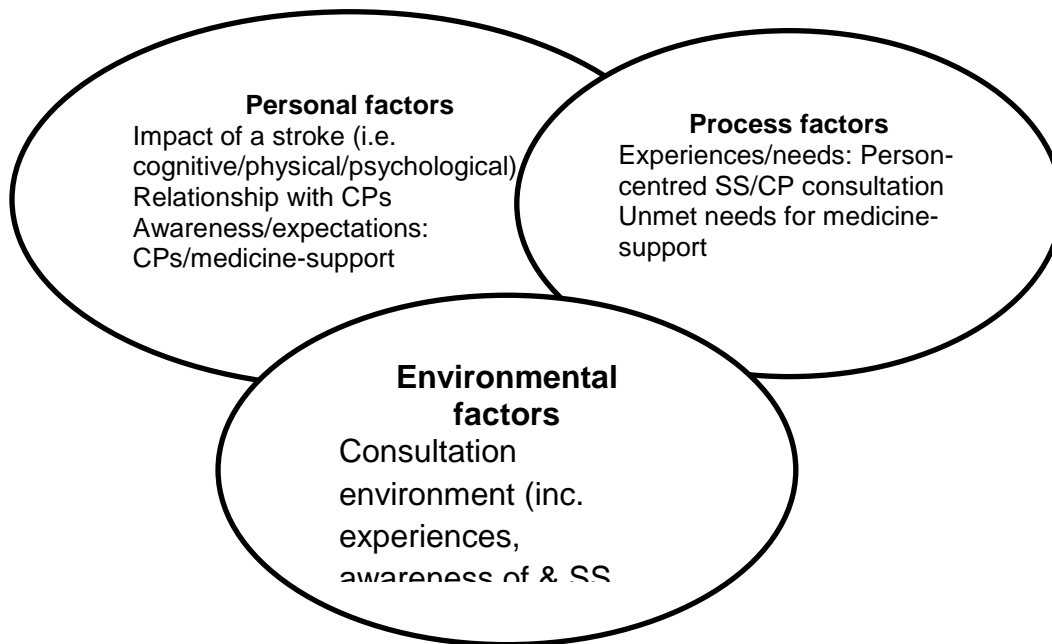


Figure 2: Community Pharmacist Framework

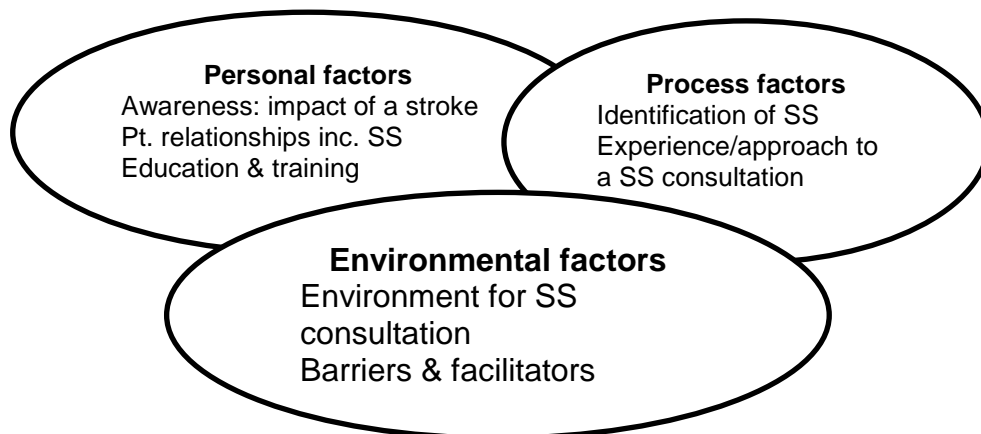


Figure 3: Consultation Tool

A CONSULTATION TOOL TO OPTIMISE PERSON-CENTRED DISCUSSIONS ABOUT MEDICINES WITH STROKE SURVIVORS

This tool is based on semi-structured interviews with stroke survivors and community pharmacists, research literature and recommendations from the Stroke Association

It offers guidance for building a **trusting relationship**, promoting **communication** and **identifying and resolving medicine-related problems with stroke survivors**, which may encourage people to **return to you** for support

STARTING OUT

- ❖ It is important to **identify** stroke survivors - their **needs might be specific** and **not obvious**
- ❖ **Prescribed medicines** provide a clue that a person has had a stroke - but **you won't know unless you ASK!** Stroke survivors tell us they **don't mind being asked** - they feel **it is important for you to know**
- ❖ Stroke survivors want you to know **how their stroke has affected them**

You could ask or invite the person to complete one of the '**Getting to Know Me**' forms
There are **two versions** of the form: **a) written b) aphasia friendly**
Ask the stroke survivor **which form they prefer** to use

- ❖ They would like you to **know them as a person** and to **get to know you** too
- ❖ Find out if the stroke survivor wants **someone with them** during their discussion, such as spouse, relative or carer
- ❖ Be sure to **record all important information** - this will mean that the stroke survivor **does not have to repeat** information to your colleagues and will **always receive the best possible support**
- ❖ Stroke survivors would like you to have the **latest knowledge** and be a **specialist about their medicines** - see NICE Guidance for Stroke:
<https://www.nice.org.uk/guidance/cg68/chapter/1-guidance>

GETTING THE BEST FROM THE CONSULTATION
Stroke survivors have told us **the points below are important to them...**

Arranging to meet

- ❖ Ensure you meet at a time **suitable for the stroke survivor** - some people feel better at different times of the day because of their stroke
- ❖ Always **allow sufficient time** - discussions may take longer than usual

Optimising the environment

- ❖ Stroke survivors prefer a **private, quiet** and **unconfined space** - always **ask** the person if they prefer to talk in the **consultation room**
- ❖ Choose a place where the stroke survivor, and possibly their carer, can **sit down** - it should be **accessible to a wheelchair**
- ❖ Try to **limit distractions** such as background noise, interruptions and too much visual information

Remember - some stroke survivors have **difficulty visiting their pharmacy** due to the effects of their stroke
If possible, try to arrange **other ways to meet with them**, such as **visiting their home**
If this is not possible contact by **telephone** is better than nothing!

Optimising communication

- ❖ Take into account the **individual's specific needs** before you start - you will probably need to **explore these in more depth during the first consultation**
Remember - the **patient** is often an **expert about living with their condition**
- ❖ **Introduce yourself** as the pharmacist, don't assume stroke survivors know you as the pharmacist, and **explain what you are going to do** - i.e. to help them with their medicines
- ❖ **Don't speak too quickly**
- ❖ Allow the person **time to speak** - **listen actively** and be sure to **not interrupt or finish sentences**
- ❖ Keep sentences **simple and concise**
- ❖ **Don't keep moving between topics** - changing subjects quickly can be confusing
- ❖ **Don't seem rushed** - appear relaxed, approachable and that you have time
- ❖ Use **repetition** - i.e. to reinforce important points and to check understanding (visually/verbally)
- ❖ Make sure that you **always include the stroke survivor** in the discussion - **keep face to face contact** with the stroke survivor - especially in the presence of carers
- ❖ **Use communication tools wisely** - they can be useful if someone has memory or communication difficulties - but leaflets are not any good if you cannot read
- ❖ Sometimes it is better to ask **short yes/no questions** instead of open questions
- ❖ **Check reliability of responses** - some stroke survivors may jumble their words - **'no' might mean 'yes'!** In such cases, **tick/crosses** or **thumbs up/thumbs down** may help
- ❖ Ask if a **break** or **rest** is needed - notice **verbal** and **non-verbal signs of fatigue**
- ❖ **Taking notes** during the consultation **can communicate interest and attention**, and **support continuity of care**. However, it **should not be the focus or a distraction** to the discussion - always **ask if it is okay to take and keep notes**
- ❖ Be careful **to not patronise** - people can sometimes **lack confidence** after their stroke - remember stroke survivors are adults who have had a life-changing experience

Remember - The **Stroke Association** has produced excellent **guidance** for helping to overcome communication difficulties with stroke survivors - search their website for their tips: www.stroke.org.uk/

Developing joint-solutions to identified medicine-related problems

Research has indicated that **stroke survivors often do not identify or report medicines problems** which could be easily **resolved - by changes in presentation** (formulation, packaging) or **routine** (dosage frequency, memory aids)

- ❖ Make sure that you **jointly recognise a problem** and **agree a solution**
- ❖ **Consistency in the supply of medicines** can be particularly important to stroke survivors - **changes in brand should be limited and communicated**
- ❖ Remember to **follow-up** to see if the agreed solution has worked
- ❖ It may be appropriate to **liaise/share information** with other **healthcare professionals**, **ask the patient**

Helping stroke survivors recognise what you can do for them

- ❖ Stroke survivors often have **limited awareness of the support that pharmacists can provide** - use every opportunity to **share what services you provide** - is there a **poster** advertising medicine support? You could also **promote that you are sensitive to the specific needs of stroke survivors**
- ❖ **Efficient and timely supply of medicines** can be particularly important for stroke survivors and is a key factor in **building trust, better relationships** and **opportunities for offering future support**