

GIAF-UGR

Pharmacotherapy follow-up: The Dader method (3rd revision: 2005)

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ABSTRACT*

The Dader Method for Pharmacotherapy Follow-Up was created in 1999 to implement the process laid out by the Dader Programme and it was revised in 2003. Since then, pharmacists have provided us with their remarks and comments on the programme, and some research was also made. Some of those have allowed for another revision to be carried out.

The aim of this work is to present the Dader Programme in its current state, following its third revision. This revision has been carried out with the aims being globalisation and simplification of the programme. Globalisation, so that the programme is standard practice and can be used by any pharmacist working with any patient, whatever the treatment for their illness. And simplification, because for a procedure to become a widespread practice, it has to be as easy as possible to follow, without losing the precision of a standardised operational procedure.

Keywords: Pharmacotherapy follow-up. Process. Outcomes.

RESUMEN

El Método Dáder de seguimiento farmacoterapéutico nació en 1999 para dar cobertura al proceso que se enseñaba en el Programa Dáder y había sido revisado en 2003. Desde entonces se han producido un buen número de comentarios de los farmacéuticos, y se han concluido algunas investigaciones que permiten realizar una nueva revisión.

El objetivo del presente trabajo consiste en presentar el Método Dáder en el estado actual, tras su tercera revisión. Esta revisión se ha hecho con los objetivos de universalización y simplificación del Método. Universalización, para que el Método sea un estándar de práctica que pueda ser utilizado por cualquier farmacéutico trabajando con a cualquier paciente, sea cual fuese su tratamiento para su enfermedad. Y simplificación, en el convencimiento de que para que un procedimiento se pueda extender y convertirse en una práctica generalizada, habrá de ser lo más simple posible, sin que por ello pierda el rigor de un procedimiento operativo normalizado.

Palabras clave: Seguimiento farmacoterapéutico. Proceso. Resultados.

(English)

PREFACE

The Dader Method began as a support to the Dader Programme in 1999. From the beginning its aim was to create a simple operative procedure that allowed for pharmacotherapy follow-up to be carried out on any type of patient, suffering from any type of illness or health problem, in any setting and by any pharmacist.

Over the course of more than five years of using pharmacotherapy follow-up, in various care levels, the use of this method has resulted in experiences gained that have contributed to the improvement of the Method. On the other hand, the investigations carried out in this area, using the data collected thanks to the intervention forms forwarded to the Dader Programme, have allowed for the fine-tuning of the operative procedures even more than was thought possible five years ago. As expected, information from the two earlier revisions of the procedures has brought useful information to this revision.^{1,2}

As was the case after the finalisation of the pilot phase of the Dader Programme,³ it is currently recommended that a revision of the Dader Method

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take place with two main aims: globalisation and simplification.

Globalisation is understood here in the widest sense of the word. The first thing would be to achieve an operative procedure that would be applicable in any country in the world, and also one that is applicable at any care level. However, perhaps more important than this last point, it would be necessary to rely on an operative procedure that is applicable to all different existing settings within the same care level, usually due to their different structure, and that influence the practice more than the level they belong. Therefore, the existence of information technology in a department, the capacity to be able to interview patients or not, the availability of information sources, the presence of a member of staff dedicated exclusively to pharmacotherapy follow-up are all more determining features of the process than the actual level to which the department belongs. All these should be taken into account when the Method is being revised.

Simplification is the main reason for the revision. On many occasions the modification of an operative procedure means the addition of new functions and activities without the elimination of ones that were obsolete or ones that had been improved upon by these new ones. If we hope to achieve (and we probably all do) that pharmacotherapy follow-up becomes an activity incorporated into a large number of pharmacies and pharmacy departments, and we aim to make it available to a large number of patients, the operative procedure upon which it is based will have to be so simple that all pharmacists and departments can carry it out without its current structure serving as a barrier. The reason for the creation of an operative procedure is to allow for an activity to be carried out in the most efficient way by using this procedure rather than if it was simply carried out *secundum artis*.

Over the years, the Dader Method has proved to be an operative process which has helped many pharmacists implement pharmacotherapy follow-up in their pharmacies or pharmacy departments.^{4,5} The recent revision, and future ones too, should be seen as a system for fine-tuning and improving this Method, as well as incorporating the results of the investigations that are being carried out in the pharmacotherapy follow-up field and in pharmacy practice in general.

ANTECEDENTS

The 2001 Spanish Consensus on Pharmaceutical Care⁶ defined pharmacotherapeutic follow-up as "the personalised practice in which the pharmacist takes responsibility for the patient's needs regarding their medication, via detection, prevention and resolution of the drug-related problems (DRP), in a continued, systematic and documented way, in collaboration with the patient themselves and with other healthcare professionals, with the aim of reaching specific outcomes that improve the patient's quality of life".

The 2002 Brazilian Consensus on Pharmaceutical Care⁷ provides an almost identical definition: "It is a

component of pharmaceutical care and is a process in which the pharmacist is responsible for the needs of the user with regards to their medication, via detection, prevention and resolution of the drug-related problems (DRP), in a systematic, continuous and documented way, with the aim being to reach clearly defined results and an improvement the quality of life of the user".

Although there is no existing agreement on which is the exact English term for pharmacotherapy follow-up, there are two concepts which are quite similar. In 1990 Hepler and Stand⁸ defined Pharmaceutical Care as "the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life.... Pharmaceutical Care involves the process through which a pharmacist cooperates with a patient and other professionals in designing, implementing and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient. This in turn involves three major functions: 1) identifying potential and actual DRPs, 2) resolving actual DRPs and 3) preventing potential DRPs".

More recently in 2004, the Pharmacy Profession Stakeholders Consensus Document confirmed that "Medication Therapy Management encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's, or other qualified health care provider's, scope of practice. These services include but are not limited to the following, according to the individual needs of the patient:

- a) Performing or obtaining necessary assessments of the patient's health status;
- b) Formulating a medication treatment plan;
- c) Selecting, initiating, modifying, or administering medication therapy;
- d) Monitoring and evaluating the patient's response to therapy, including safety and effectiveness;
- e) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;
- f) Documenting the care delivered and communicating essential information to the patient's other primary care providers;
- g) Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications;
- h) Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens;
- i) Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient.

What does remain clear in all of these definitions is that there is a universal activity which concentrates on identifying, preventing and resolving drug-related problems (DRPs) [or medicine-related problems]. The issue is currently consigned to knowing what those drug-related problems are.

INTRODUCTION

The Dader Method is an operative procedure for the benefit of pharmacotherapy follow-up in any care level and for any patient. The application of this operative procedure aims at creating some standards of practice that guarantee the efficiency of the service, and above all the safety of the patient.

The negative clinical outcomes associated with pharmacotherapy are of particular concern and an issue which has been described as being a public health problem.¹⁰ It is estimated that one in every three patients who go to Accident and Emergency departments, do so for having suffered from a pharmacotherapy negative outcome. This figure is made worse when 75% could have been avoided, perhaps by carrying out pharmacotherapy follow-up. This problem is not exclusive to rich nations as was originally thought to be the case.¹⁴⁻¹⁸

There has been a lot written about the concept of drug-related problems, and from it all it can be deduced that it is a polysemic concept, which is to say that different authors understand various different concepts under this same denomination. Some take DRP to signify the elements of the process of use of medication that can lead to a negative outcome.^{19,20} Others understand it to be the actual clinical outcome associated with pharmacotherapy.²¹ This was the meaning that the Granada Consensus adopted regarding problems related to medication. In their second revision,²² DRP was specifically defined as being "health problems, understood as being negative clinical outcomes, resulting from pharmacotherapy that for many reasons, lead to the therapeutic aim not being carried out or the appearance of undesirable effects". In scientific terms, polysemy is something that should be avoided and it would seem advisable that terms that are more in accordance with common health science terminology be used, i.e. negative clinical results of pharmacotherapy.²³ Here outcome²⁴ understood to be the "change in the patient's health status as a consequence of the care service"; the clinical results are one of three types of results outlined in the ECHO model.²⁵

OPERATIVE PROCEDURE

The following section describes the operative procedure that has become known as the Dader Method of pharmacotherapy follow-up. This procedure is structured in a similar way to the rest of the health care processes. Firstly, information about the state of health of the patient and the medications that are used must be obtained. This is used to form a document known as an assessment form, which is evaluated once all the necessary information has been added. The result of this assessment will be a set of suspected anomalous situations upon which the professional will decide whether to intervene with the measures at his or her disposal, with the aim of achieving an improvement in patient's health status.

Initiation of Service

The initiation of service, also known as service offer, is one of these activities which is largely influenced by the environment and structure in which the pharmacotherapy follow-up is being carried out. More than just about the types of services or the different care levels, the initiation of Service is influenced by the person who takes the decision to accept a care service for a specific patient. Although under patients' autonomy principal, it should always be the patient that makes the final decision when it comes to accepting the treatment that they are going to receive, in practice this is not always the case. In institutions such as health care residences,²⁶ or in hospitals,²⁷ and also in day clinics or primary care clinics,²⁸ the decision to accept a new professional into the care team is not usually the patient's decision, but that of the doctor in charge. This means that in these types of institutions, the offer of service is frequently not given to the patient, but to the professional in charge of choosing the medication.²⁹

In the case that the service offer is directly put to the patient, the techniques of communication are of special importance. The paternalistic figure, known as the "medical model" is not in use any more.³⁰ An assertive and positive expression helps to captivate the patient's interest without arousing any fears they may have regarding pharmacotherapy. Phrases such as "we can help you improve the outcomes of the medication" or "we are going to try to improve you [your health problem]" are good for initiating the desire to be helped by this service.

When the offer is carried out by the doctor, actual medical inter-trade language can be the most adequate, as can the support material (such as) medical communication forms. In those departments where pharmacotherapy follow-up is already implemented, it is not necessary to offer it to every new patient; quite simply, the communicating the gathered facts or intervention (see further on) can be the best form of communication.

One of the recurring doubts when first using pharmacotherapeutic follow-up is which patients to start it on. On this point, and especially for community pharmacies, there are those who believe that it is best to start with patients that have a complaint or concern, given that this would be the best method for gaining their attention. Others believe it is best to start with patients who are already being attended to with another service, such as those receiving dietary advice, or help in controlling an area such as blood pressure or glycaemia.³¹ Lastly, it is not incorrect to choose patients whose medication either presents narrow therapeutic margins or poses difficulties for its use, due to its pharmaceutical form. In hospitals that have more than just one medical department available, it seems that the most successful practice is that of selecting a patient who initially accepts the collaboration.²⁷⁻³²

Information about the Patient

Sometimes it is thought that the only way to gather information on a patient is by carrying out an interview, which is why this part of the operative procedure is usually termed interview.³³ Advances in recording data and in the definition of operative procedures in other activities similar to pharmacotherapeutic follow-up, such as dispensing, have resulted in community pharmacies, hospital pharmacies and also elderly residences having their patients' pharmacotherapeutic records on file. Once again, the differences in the procedures do not depend so much on the level of care, rather the structure of the pharmacy or department in which it is offered.

In any case and whatever the level of care, the patient's interview can provide information that was not in any patient medication record. For example, the patient's worries determine the level of sacrifice he or she is willing to make in the recommended interventions. If the pharmacist has not carried out an interview, then it will be hard for them to know what the degree of preoccupation is presented by each health problem. At the same time, a voluntary lack of compliance is practically impossible to detect by looking at a patient medication record. Nor is there any insurance that a institutionalized patient takes his or her prescribed medication, except in the case that there exists a direct observed treatment.

If an interview is carried out with the patient, it is useful to structure it in to the three stages that appear in the original Dader Programme documentation: open-ended questions about the problems faced by the patient, closed questions about the medications used by the patient and then a general recap.

- The open question attempts to establish the patient's main concerns regarding their health. From "how is your health?" to "what concerns you most about your health?". The pharmacist should choose a question which they feel comfortable with in front of the patient. The questions should provoke an open answer from the patient and one in which the patient describes the problems they suffer from and those which seem most important to them. During the patient's answer, the pharmacist should acknowledge that it is an open question and should therefore not interrupt the patient. An interruption may cause the patient to forget the other problems they wanted to mention, or it may cause them to change the apparent importance they gave to a particular problem. The social desirability and the fear of seeming ridiculous are aspects the pharmacist must dispel with an assertive posture.
- The ten questions that appear on the original Dader Programme documentation are the basic information that must be gathered on each medication used by the patient. This does not mean to say that each one of the questions must be asked in order for each of the medications. The aim of these questions is to gather sufficient information so as to determine if the patient knows how to use each medication, and also to

find out if the patient is complying, or willing to comply with the instructions of use. For this stage of the procedure it is useful to take the medications the patient takes as a starting point, on those that they can take home from the selection of medications available, or on the pharmacotherapeutic history which is held electronically on the system. In this last case, it has proved useful that the pharmacists take the medications and lay them out for the patient to see, as a patient does not always know the medication by name, but they do recognize the packaging they come in.

- In the general recap stage, there are two aims: on the one hand, the opportunity to gather more information about the patient's health problems that they may not have elaborated on in the open questions because they didn't consider them to be important enough; and also the aim is to discover if there are any other health problems or any medication that have not appeared in the two previous stages of the interview. Whichever form the pharmacist feels most comfortable with and is most helpful for gathering information is valid. The original Dader Programme documentation recommended, (because it has been proved useful), that a sequence of questions is followed starting with major symptoms of bodily organs in a descending order: "Do you take anything for headaches?", "Do you have problems with your vision or hearing, or do you get dizzy spells?", "Do you take anything for catarrh, allergies, coughs?", "you mentioned that you have back aches, are they very frequent?", and how many pills would you take each day that it hurts?", and so on, imaginarily descending down the body and through the more common problems, but particularly emphasising those areas related to the medication that we have established the patient is taking.

Assessment Form

With the information obtained from the patient, pharmacotherapeutic records or clinical records, or better still from all of these together, an assessment form should be able to be filled out. This part of the operative procedure, together with the systematic assessment, make up the very nucleus of the Dader Method. If an assessment form is correctly filled in, the assessment will not present any problems, and therefore will easily identify all the patient's negative clinical outcomes associated with the pharmacotherapy, or the patient is at risk of suffering. However, when an assessment form is incorrectly filled out, the most likely scenario is that the whole Method fails.

The assessment form was designed following pharmacists practicing pharmacotherapy follow-up,³³ and recently it has been modified to make it more efficacious.³⁴ The key element of this model of assessment form is the paring-off of the health problems with the medication used for their treatment. The criteria for the paring-off is as follows: The therapeutic aim of each treatment is the alleviation, cure or improvement of each of

health problem listed on the left. As can be seen further on, this is so as to be able to correctly evaluate the effectiveness of some treatments. This aim is necessary so as to separate the assessment form into different lines in keeping with each of the therapeutic objectives. For example in patients with persistent asthma, the supporting treatment (corticosteroids, long term beta agonists) has a therapeutic aim which is clearly different to the fast-acting treatment (short term beta agonists), which therefore leads us to place them in to two different lines on the assessment form; this will be the only way in which the effectiveness of each of them will be evaluated for its therapeutic aim.

The recent modification of the layout of the assessment form consists in providing two different columns for the schedule: One for the prescribed schedule and another for the schedule actually used by the patient. Originally the assessment form only indicated whether the patient knew how to take the medication and whether he or she complied with this schedule. The answer was a simple 'yes' or 'no' to each of the questions, lacking the rest of the information. On the other hand, in that box, not only the schedule (prescribed or actual) should be indicated, but also the special conditions for administration. The necessary conditions (in the prescribed schedule) just as much as those the patient carries out in reality. This acts as a control of the elements that should have been carried out in the dispensing process.³⁶

Information on medications and health problems

The existence of thousands of active substances, each with various adverse effects and all used in a huge variety of symptoms, means that a recap what is known is needed before each assessment. In this compilation and updating of the information, it is as necessary to concentrate on the medication and its effects, as on the health problems and their signs and symptoms.

Occasionally, following this collection of additional information, the assessment form can be modified. For example, to discover that one of the health problems added on at the end is an indicator of the lack of control of one of the existing problems, would lead us to place it on the same line on the assessment form. Discovering that a treatment which is given concurrently does not have a synergic action, but instead has various therapeutic aims against concurrently occurring problems in a pathological situation, (e.g. cold-flu and treatment with antihistamines, vasoconstrictors and analgesics) would lead us to place that on a separate line, paring the medication off with its corresponding therapeutic aim.

When the pharmacist inquires into the different health problems, they should not do it to verify the diagnosis. Recognising the signs and symptoms of each illness and in particular their clinical manifestations, aims to evaluate the degree of control of this health problem, in other words, the level of effectiveness of the treatment. Therefore,

parameters of normality and signs and symptoms of lack of control are key elements to be aware of with each health problem mentioned on an assessment form.

With regards to medication, the dose margins usually taken should be revised. Also for revision should be the basic pharmacokinetic elements enabling the establishment of the therapeutic margins of medication. It is also necessary to know what the desired therapeutic effects are after having taken the medication and that they should coincide with the parameters of control that have been revised in the section on health problems. Lastly, it is necessary to know about possible problems that can arise from using this medication, and very importantly, the way in which they manifest themselves in the patient.

In both the case of medications and health problems, the information to be used should be of very easy application. In other words, it should allow for one a situation described in the literature to be recognised or suspected in the patient. When carrying out pharmacotherapy follow-up, there is no benefit in generating an excess of warnings unless they are based on well-founded suspicions. There are those who express the idea of pharmacotherapeutic follow-up as "looking for possible solutions to real problems".

The drug information centres can be good areas for help in these cases. There are an ever increasing number of pharmacists working in these centres, each highly educated in the field of pharmacotherapeutic follow-up which will increase the applicability of the information they provide.³⁷

Assessment

The creation of the assessment form (see annex) makes up the core of the Dader Method. However, as previously stated, if the assessment form is adequately compiled and all possible information was gathered, the evaluation should not pose any problems. The procedure would be as simple as following the algorithm,³⁸ taking into account the following definitions:

- A treatment (the given set of medications for a health problem) is considered to be necessary if it has been knowingly prescribed by a prescriber for a health problem detected in the patient.
- A treatment (the given set of medications for a health problem) is considered to be effective if it sufficiently controls the health problem for which it was prescribed.
- A medication is considered safe if it does not cause or destabilize a health problem in the patient.

In order to identify quantiveness of the negative outcomes of ineffectiveness and insecurity, the criteria to be followed, taking into account the limits of the therapeutic margin adapted to the specific patient³⁹ are as follows:

- For ineffectiveness: Is the amount of medication working on the patient too low? If so, ineffectiveness is dependent on the amount, therefore, quantitative.
- In the case of unsafe: Is there an excessive amount of medication working on the patient? If so, the lack of safety of the medication will be dependent on the amount, therefore, quantitative.

The result of this phase of the procedure should be a set of suspected negative clinical outcomes associated to pharmacotherapy, upon which it would be possible to take action via individual interventions.

Intervention

Intervention⁴⁰ is the "action that arises from an earlier decision and one which aims to modify a particular characteristic of the patient that is using it, or the conditions in which it is encased.

At this stage of the process, it would be illogical to decide to act upon every case where negative results associated to pharmacotherapy are identified. Ideally, generating an action plan that would extend over time until an evaluation of the patient's next assessment form is carried out. There are certain useful criteria for prioritizing interventions when it is not necessary to intervene in all:

1. Those posing a serious risk for the patient.
2. Any problem that could be solved in the short term, chosen from the whole set of problems concerning the patient or pharmacist.
3. The remainder

The recipient of the intervention should be the person who is to make the decision to modify the process of use of the medication. Sometimes the recipient will be the patient, since the aim is to modify and adjust the use of his or her medication. This will be done either following the physician's instructions or following the rules for correct administration. On other occasions, some modification of aspects of the pharmacotherapy may be necessary. Therefore, the prescriber would be the recipient, as they are the one responsible for the treatment (medicine, dosage, pharmaceutical form, etc.)

Another point that arises here can be addressed in different ways depending on the different environments: the methods of communication with the physician. Unfortunately, on many occasions, community pharmacies are not considered to be a part of the health system. This implies that communicating health data without the express authorization of the patient would make the legislation on data protection vulnerable. This does not happen within institutions, where data transmittal would not be considered. It is hoped that new technologies, such as electronic prescriptions or computerized clinical records with possible telematic access will allow for this difference to be eliminated.

The other choice to be made is with regards to the way in which the intervention is communicated to

the recipient. Whether the recipient is the patient or the physician, in many cases the written form should be used, mainly because it allows for more accurate communication. When the intervention is communicated to the physician, some specific models have been designed for pharmacotherapy follow-up.⁴¹ Either these letter-type templates or formatted medical communication forms can be used.²⁸ The important thing is that the communication must clearly state who the patient is, what their detected problem is and what the pharmacist's clinical judgment is, if it helps to understand, (or solve) the problem.

The original Dader Programme intervention form (see annex) comprises three parts: an initial description of the negative outcome associated to pharmacotherapy that has been identified, a second part describing the desired course of action and how it is going to be carried out, and finally a third part reproduces the results of the intervention.

Recent research has proved that the range of possible actions is not unlimited; therefore it is a range that can be narrowed down to nine types, thereby simplifying the original model.⁴⁰

The objective of pharmacotherapy follow-up is the improvement of a patient's health; this is to say, improving the outcomes of medication used. A common mistake among those only initiating a pharmacotherapy follow-up is to believe that it is sufficient just to pinpoint the negative clinical outcomes associated to pharmacotherapy. Further on in the process, once an intervention has identified negative clinical outcomes, it tends to be taken as a justification of the pharmacist's work being complete. None of this is acceptable for a health professional who, as the name implies, should be in pursuit of the patients' optimum health status. Therefore, the aim of the follow-up cannot be to identify negative outcomes of the pharmacotherapy nor the intervention itself, but rather the resolution of that negative clinical outcome. Thus, in the part of the form related to the results of the intervention, a difference will have to be established between the results of the follow-up process (which occurred with the intervention), and the patient's health outcomes (what happened with the specific health problem).

However, it should be remembered that the final output of an intervention is a new assessment form. This completes the loop in the ongoing process of pharmacotherapy follow-up. The knowledge of the health problems and medications will have to be revised on the Assessment form, then evaluates, at which point new suspected negative clinical outcomes associated with pharmacotherapy will appear, which themselves will have to be intervened upon, and so on and so on. The frequency that this loop is repeated depends on many situations, but mainly it would depend upon the severity of the patient's situation or on the frequency with which changes are expected in the patient's health status. This has the effect that for patients who are hospitalized in an acute state, the cycle can take place several times a day, whereas with more stable ambulatory patients, it can take place over

several months. Once again, it is not the care level that makes the difference, but the patient's situation (i.e. the repetitions will have to be to almost daily for ambulatory patients on initiating an insulin programme).

EPILOGUE

As was said at the beginning, this review has been made possible thanks to the contributions of the pharmacists that have used the Dader Method, and also to the research on interventions forwarded to the Dader Programme. We would like to stress the importance of sending in the interventions; they

have served to evaluate the errors and imperfections of the Method itself.

This said, The Pharmaceutical Care Research Group of The University of Granada, would like to stress that all those interested in pharmaceutical follow-up should participate in the Dader Programme. Comments on the use of the Dader Method at all care levels and from any country will be gratefully received. Ultimately it is the patient and their health that benefits from the reviews and revisions of the Method.

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Pharmacotherapy Follow-up: Pharmacist intervention

Date: ___ / ___ / _____

Patient:

□	□	□	□	□	□	□	□	□	□	□	□
---	---	---	---	---	---	---	---	---	---	---	---

Health problem:

Identification

Medicines(s) involved	
Code	Name, power and form

Identified negative outcome (tick just one)	
<input type="checkbox"/>	Untreated health problem
<input type="checkbox"/>	Effects of an unnecessary drug
<input type="checkbox"/>	Non Quantitative ineffectiveness
<input type="checkbox"/>	Quantitative ineffectiveness
<input type="checkbox"/>	Non Quantitative unsafe
<input type="checkbox"/>	Quantitative unsafe

Situation (tick just one)	
<input type="checkbox"/>	Actual problem
<input type="checkbox"/>	Risk of appearing

Cause (tick just one)	
<input type="checkbox"/>	1. Interaction
<input type="checkbox"/>	2. Non-compliance
<input type="checkbox"/>	3. Duplicity
<input type="checkbox"/>	4. None of them

Action

What is intended to solve the problem: (tick just one)		
Intervene on the quantity of drug	Modify the dose	<input type="checkbox"/>
	Modify the dosing	<input type="checkbox"/>
	Modify administration schedule	<input type="checkbox"/>
Intervene on the therapeutic strategy	Add some medicine(s)	<input type="checkbox"/>
	Withdraw some medicine(s)	<input type="checkbox"/>
	Substitute un medicine(s)	<input type="checkbox"/>
Intervene on patient education	Reduce involuntary non-compliance	<input type="checkbox"/>
	Reduce voluntary non-compliance	<input type="checkbox"/>
	Educate in non-pharmacological measures	<input type="checkbox"/>
Not clear		<input type="checkbox"/>

Comm. route (tick just one)	
<input type="checkbox"/>	1. Oral to the patient
<input type="checkbox"/>	2. Written to the patient
<input type="checkbox"/>	3. Oral to the physician
<input type="checkbox"/>	4. Written to the physician

Date of revision

Result

Date ending the intervention

What happened with the intervention?

What happened with the health problem?

Num. Medicines used (on initiating the intervention):

Result	Solved H. problem	Non Solved H. problem
Accepted intervention	<input type="checkbox"/>	<input type="checkbox"/>
Non accepted intervention	<input type="checkbox"/>	<input type="checkbox"/>