



The Self-Medication Assessment Tool (SMAT)

Training Program



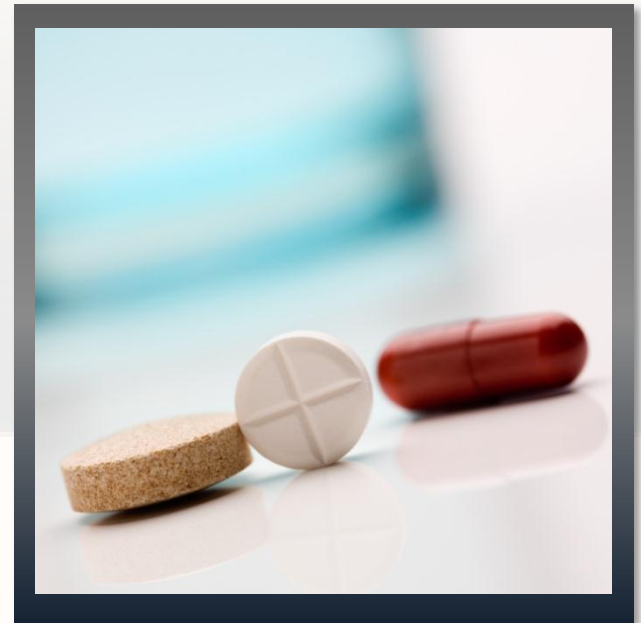
The Self-Medication Assessment Tool (SMAT) Training Program

Contents

Module I: Introduction and Background

Module II: Administration and Scoring

Module III: Interpretation and Making Recommendations



The Self-Medication Assessment Tool (SMAT) Training Program

Module II: Administration and Scoring

Part A: Preparing for the Assessment

If you have not already done so, we recommend that you print a copy of the SMAT form and the Instructions for Tester at this time to make it easier to understand the materials that follow.

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Contents of the SMAT Kit

The SMAT kit contains a standard set of the contents needed to fully assess the participant, in a small, easy to carry container.

Before beginning an assessment, always check the kit to make sure the contents are complete and undamaged.



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Contents of the SMAT Kit

Pill bottles of varying sizes with printed information in several standard font sizes.



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Contents of the SMAT Kit



One 7 dram prescription vial, arrow line up safety cap type, labelled in 10 point font



Local Pharmacy Ltd.

5200 Main Street Moncton, NB E5C 1H1
(506) 555-2121

Rx#10052

Ref: 6

Dr. E. L. Smith

TAKE 1 TABLET DAILY

Vitamin E 400 IU

Vitamin E 400 IU

28 TABS

23 May 2006

Above refills expire 23 May 2007



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Contents of the SMAT Kit



One 12 dram prescription vial, push & turn safety cap type, labelled in 12 point font



Local Pharmacy Ltd.

5200 Main Street Moncton, NB E5C 1H1
(506) 555-2121

Rx#10052

Ref: 6

Dr. E. L. Smith

TAKE 1 TABLET DAILY

Effexor XR 150 mg

Venlafaxine XR 150mg

28 TABS

23 May 2006

Above refills expire 23 May 2007



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Contents of the SMAT Kit

Three 40 dram prescription vials, flip top caps, labelled in 14 point font



Local Pharmacy Ltd.

5200 Main Street Moncton, NB E5C 1H1
(506) 555-2121

Rx#10050 Ref: 2 Dr. E. L. Smith

TAKE 1 CAPSULE THREE

TIMES DAILY

DILANTIN 100 MG

PHENYTOIN SOD EXTENDED

100 MG 00022780

84 CAPS 23 May 2006 Above refills expire 23 May 2007



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Contents of the SMAT Kit

- Each of the prescription vials is identified with a standardized label similar to that used in community pharmacy practice.
 - The instructions on the 7 dram and 12 dram vials read, “take one tablet daily.”
 - The instructions on one of the 40 dram vials read, “take one tablet three times daily.” The instructions on the other two 40 dram vials read, “take one tablet daily.”
- Each prescription vial contains actual medication and the instruction on the label is realistic for that medication.
 - Example: Vial contains EC ASA 81 mg and label reads, “take one tablet daily.”

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Contents of the SMAT Kit

Two weekly pill organizers are included, one filled and one empty. Each column of the organizer can be removed (i.e.: Monday's pills, Tuesday's pills, etc.).

Source: www.pharmasystems.com
Product ID # 1138



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Contents of the SMAT Kit

A pharmacist-prepared weekly blister package is also included.

Source: Medi Pack Card/Blisters Item # T-12 INTROTRI Cold Seal Packaging
100/case from Jones Packaging 1-800-265-1009



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Contents of the SMAT Kit

Two smaller blister packages are included, to test for ability to see light- and dark-coloured medications.

This one is for light colours...



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Contents of the SMAT Kit

...and this one is for dark colours.



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Contents of the SMAT Kit - Review

- ✓ 1 x 7 dram prescription vial, arrow line up safety cap type, labelled in 10 pt font
- ✓ 1 x 12 dram prescription vial, push & turn safety cap type, labelled in 12 pt font
- ✓ 3 x 40 dram prescription vials, flip top caps, labelled in 14 pt font
- ✓ 2 weekly pill organizers (dosettes); 7 – day type (Sunday to Saturday) with four slots per day for storing medication
 - ✓ One pill organizer is filled for a typical week
 - ✓ One pill organizer is empty
- ✓ 1 prepared blister pack weekly compliance package
- ✓ 2 packs of coloured tablets
 - ✓ 2 x white
 - ✓ 1 each of LIGHT yellow, green, blue and purple
 - ✓ 1 each of DARK yellow, green, blue and purple

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Before the Assessment

In addition to checking the kit's contents, there are a few other tasks to complete before the formal assessment can begin. These are:

- Prepare the SMAT Assessment form
- Become familiar with the form
- Set up the environment and workspace
- Obtain consent

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Prepare the SMAT Assessment Form

All the information for the SMAT is recorded on a standard form. Some parts of the form must be prepared in advance of the assessment.

First, the patients' demographic information in Section 1 must be filled out:

Self-Medication Assessment Tool

Section 1: Demographics

Identification # _____

Date of Admission: _____

Date of Test Assessment: _____

Patient Name: _____

Medicare #: _____

Address: _____

Phone #: _____

Physician: _____

Educational Level/Work History: _____

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Prepare the SMAT Assessment Form

Next, the reference drug list must be entered on pages 5 and 6.

Note to Assessor:
It may be necessary to use more than one page for long medication lists.

Reference Drug List

Patient Recall Score								Self-reported adherence Score							
Drug Name		Drug Indication (what do you take it for?)		Dose Frequency		Description (colour, shape, dosage form, strength)		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?	
A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U

A= Able U=Unable
U indicates patient is unable to respond correctly, even when prompted or cued by the tester.

Max recall score = # of reference drugs x 4
Task score: Count of "able" responses
Recall score = (task score / max score) x 100

Max adherence score = # of reference drugs x 4
Task score: Count of "able" responses
Adherence score = (task score / max score) x 100

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Prepare the SMAT Assessment Form

- The reference drug list is defined as that list of medications that the patient was expected to be taking regularly prior to admission to hospital or another healthcare facility (e.g.: Outpatient clinic).
 - The list can be obtained from:
 - A **verified** Best Possible Medication History
 - As described by the patient, a family member or caregiver.
- AND
- Verified using prescription vials, other medication containers, and/or a prescription profile from the community pharmacy.

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Prepare the SMAT Assessment Form

- The list is transcribed into the reference drug list sections of the SMAT form for Recall, Self-Reported Adherence, and Purposeful Nonadherence.
- The tester must ensure that he/she is familiar with the medications listed (e.g.: typical doses, uses, pill colour, etc.).

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Become Familiar with the Form

Section 2 contains all the questions for the cognitive and functional assessment. For each question, the person assessing the patient checks off “ease”, “difficulty”, or “unable.” Detailed instructions are given in Part B of this module.

Section 2. Functional & Cognitive Assessment

(Bottle 1: 10pt font; child-resistant [align arrows]; 7 dram vial)

F1. *Please read the label on this bottle out loud.*

Reading the medication name:

Reading the instructions:

F2. *Please open the bottle*

C1. *If this was your medication, how would you take it?*

Dosage correct:

Time correct:

<u>Ease</u>	<u>Difficulty</u>	<u>Unable</u>

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Become Familiar with the Form

- Please refer to the “Instructions for Tester” document for complete information about the form.
 - “Ease” is checked off when the patient answers the question or does the task relatively quickly;
 - “Difficulty” is checked off when the patient makes one or more errors, or needs prompting/cuing from the tester to carry out the task;
 - and “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.

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Become Familiar with the Form

Everything the tester needs to say or explain to the patient is included on the form, in ***bold italics***.

(7 x 4 slot dosette)

This is a dosette. The names of the days are printed across the top, and the times of day are printed along the side. Here is Sunday, Monday, Tuesday, and here is Morning, Noon-time meal, evening meal, and before bed.

C5. Please point to the slot for Tuesday at noon.

F8/C6. Please take out the pills for Friday morning.

(F score)

(C score)

Ease Difficulty Unable

	<u>Ease</u>	<u>Difficulty</u>	<u>Unable</u>

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Become Familiar with the Form

Finally, the form contains spaces to record all the assessment information; there is no need to take notes or record information anywhere else during the assessment.

Do you have a daily routine that helps to remind you to take your medications? Yes No

--	--

If yes, please specify: _____

Section 4: Medication Recall/Adherence

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Environment and Workspace

- The patient and the assessor require:
 - A comfortable, quiet, and private workspace with a table and 2 chairs
 - Good lighting
 - Access to an external hearing assistance device (e.g.: “pocket talker”), for the hearing impaired if needed
 - A small magnifier device for vision impaired patients

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Environment and Workspace

- The SMAT assessment requires, on average, 45 to 50 minutes to complete.
- Ensure that the patient is prepared prior to the assessment: He/She should have:
 - accessed the washroom prior to assessment;
 - any needed assistive devices in place eg. Hearing aids, eyeglasses;
 - received any scheduled medications;
 - and should not be scheduled to eat a meal in the next hour.

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Obtain Consent

- The assessor is responsible for explaining the SMAT assessment to the patient and obtaining verbal consent to proceed. The explanation should include:
- The reasons for completing the SMAT (why it is useful):
 - E.g.: “Helps the pharmacist and you identify areas where you may be having difficulty in managing your medications.”
 - E.g.: “Helps the pharmacist to provide you with methods that can make it easier and / or safer for you to manage your medications.”

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Obtain Consent

- Describe what will be done and how long it will take:
 - E.g.: “This assessment involves answering some questions about your medications, manipulating various types of medication packaging, and will take about 45 to 50 minutes to complete.”

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Obtain Consent

- Remember to tell the patient what will be done with the information:
 - Assure the patient that you will review the assessment results with them.
 - Assure the patient that the results will be maintained as a confidential report in the patient's medical record that can only be accessed by members of the patient's healthcare team.

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Obtain Consent

- Finally, provide an opportunity for the patient to ask questions.
 - Answer with as much detail as possible, without telling the patient exactly what to do during the test.
 - Example: Patient *“I don’t see very well. What if I can’t read something?”*
 - Answer *“I just want you to do your best. If you can’t do something, just tell me and we’ll move to another part of the assessment.”*

The Self-Medication Assessment Tool (SMAT) Training Program

Please continue with the next link: [Conducting the Assessment](#)