National Prescribing Service Limited

Pharmacy practice audit: Medication management in hypertension

Improving pharmacy practice for better patient health

How are you managing:

Patients using an antihypertensive agent(s) with a diagnosis of hypertension, confirmed by the patient or their agent.

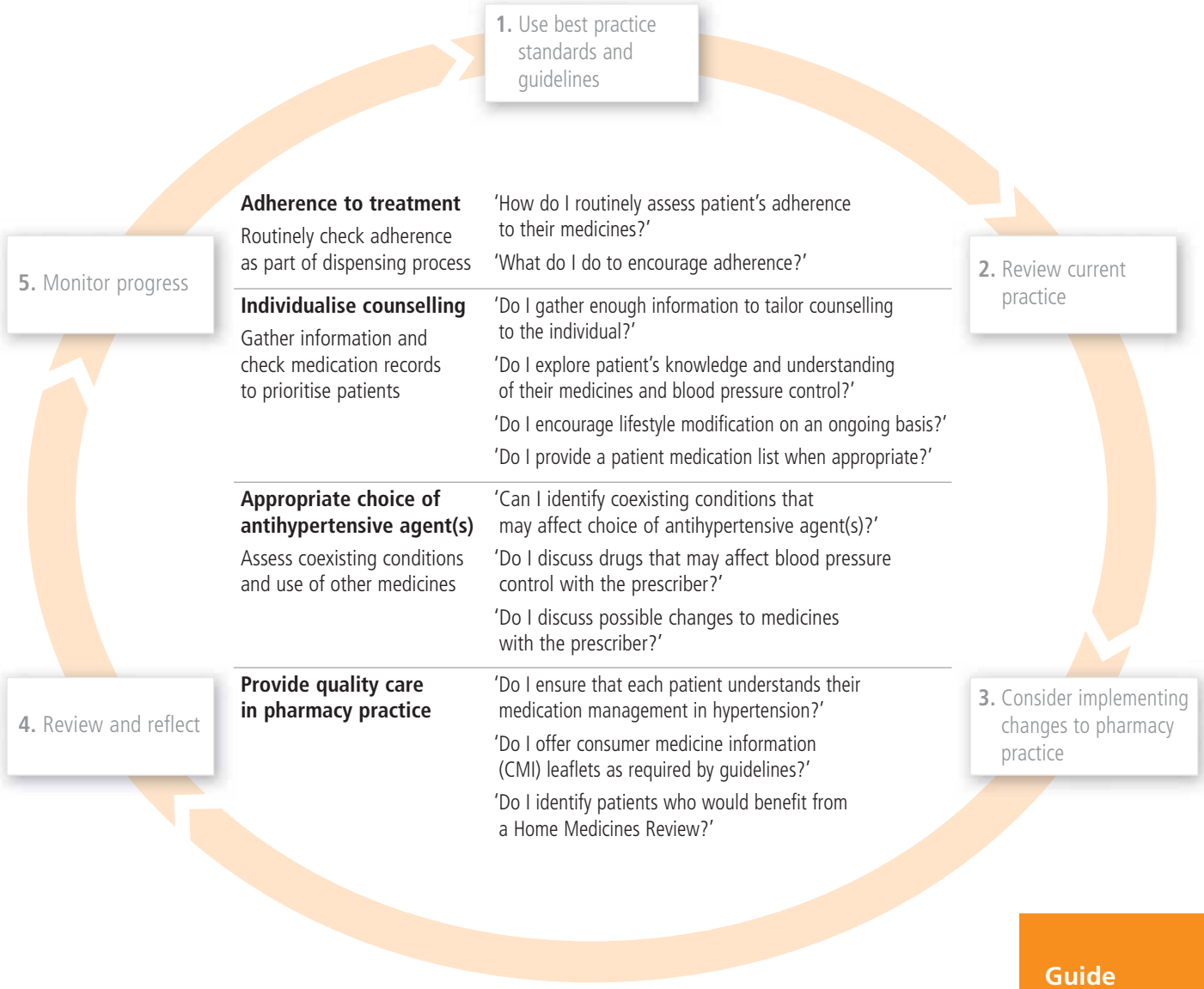
Recognised by the:

- Pharmaceutical Society of Australia (PSA) CPD & PI Program for 8 credit points.
- Australian Association of Consultant Pharmacy (AACP) for 8 credit points.
- Society of Hospital Pharmacists of Australia (SHPA) CPD record for 4 hours.

Best practice in hypertension management

This pharmacy practice audit will assist you to:

- identify drug and non-drug counselling points and encourage adherence to medicines for patients using antihypertensive agents.
- identify priorities for patient counselling.
- identify patients for GP referral, Home Medicines Review or who require assistance with adherence to medicines.
- demonstrate provision of quality care.
- self-assess your abilities against Professional Practice Standards to determine learning needs.

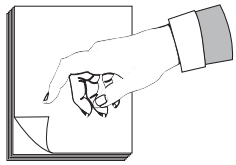


Adherence to treatment Routinely check adherence as part of dispensing process	'How do I routinely assess patient's adherence to their medicines?' 'What do I do to encourage adherence?'
Individualise counselling Gather information and check medication records to prioritise patients	'Do I gather enough information to tailor counselling to the individual?' 'Do I explore patient's knowledge and understanding of their medicines and blood pressure control?' 'Do I encourage lifestyle modification on an ongoing basis?' 'Do I provide a patient medication list when appropriate?'
Appropriate choice of antihypertensive agent(s) Assess coexisting conditions and use of other medicines	'Can I identify coexisting conditions that may affect choice of antihypertensive agent(s)?' 'Do I discuss drugs that may affect blood pressure control with the prescriber?' 'Do I discuss possible changes to medicines with the prescriber?'
Provide quality care in pharmacy practice	'Do I ensure that each patient understands their medication management in hypertension?' 'Do I offer consumer medicine information (CMI) leaflets as required by guidelines?' 'Do I identify patients who would benefit from a Home Medicines Review?'

Guide

Notes for the audit form

Additional information to assist you to review your management.



Use this information to complete the forms for patients identified as using an antihypertensive agent(s) with a diagnosis of hypertension, confirmed with the patient or their agent.

Complete one double-sided audit form as soon as possible after your selected episode of care.

Adherence to antihypertensive medicine

Routinely check pharmacy medication history as part of the dispensing process and monitor adherence.[1] To reduce barriers to adherence use a patient-centered approach that tailors combinations of strategies including:

- simplification of dosage regimens
- patient motivation
- involvement of other health professionals.[2,3]

Reducing the number of daily doses appears to be effective in increasing adherence to blood pressure-lowering medication (about 15% increase) and should be tried as a first-line strategy, although there is less evidence of an effect on blood pressure reduction.[3] Patient education *alone* appears to be largely unsuccessful.[3]

Most clinical evaluations of drugs have indicated that an adherence rate of 80% to 120% is acceptable.[2]

Use of tools and screening questionnaires can identify non-adherent patients. The Morisky instrument[4] has been validated for assessing the extent of non-adherence; however, its limitations are recognised e.g. in psychiatric patients and children, and when adherence is extremely low.[2] The questions are intended to be non-threatening and able to elicit appropriate and accurate information from the patient.[2] An introductory statement such as *'Sometimes people may forget to take medications or have difficulty taking their medications. Can you tell me if you do any of the following?'* can be used.

An Australian study found that patients who adhered to their medication regimen were less likely to experience major cardiovascular events or death. Those who answered 'yes' to the question 'Do you ever forget to take your medicines?' were more likely to experience a cardiovascular event or death.[5]

Practical tips for pharmacists to assess adherence[2]

- Ask patients non-judgmentally how often they miss a dose, e.g. "I know it must be difficult to take all your medicines regularly. How often do you miss taking them?"
- Ask patients:
  - if they are having any side effects from their medications
  - if they know why they are taking their medications
  - if they know what the benefits of taking their medications are.
- Regularly check pharmacy medication histories to assess adherence (for the medication being dispensed as well as other regular medications).
- Combine information from pharmacy medication histories with direct questioning of the patient.

Questions to ask the patient[4]

1. Do you ever forget to take your medicines?
2. Are you careless at times about taking your medicines?*
3. When you feel better do you sometimes stop taking your medicine?
4. Sometimes if you feel worse when you take your medicine, do you stop taking it?

* Alternative question: Are you irregular or inconsistent at times about taking your medicines?[2]

Inadequate adherence is defined as a 'yes' response to any of the questions, and adequate adherence by a 'no' response to all questions.

Relevant coexisting conditions or characteristics and other medicines

Coexisting conditions

Some coexisting conditions or characteristics may influence the selection of an antihypertensive agent(s) (see Table 1. Specific consideration for patients with coexisting conditions [page 5]). Choice of agent(s) should take into account indications, contraindications, precautions, associated morbidity, overall cardiovascular risk and individual response.

Relevant coexisting conditions or characteristics and other medicines (cont'd)

Medicines that may increase blood pressure

Some medicines (prescribed or over the counter) can affect BP control (see below). Consider the implications of any interaction and contact or refer to the GP if appropriate.

The following list is not exhaustive but includes the main drugs or drug classes most frequently encountered in the community setting.[6,7]

- bromocriptine (rare)
- clonidine*
- clozapine (rare)
- corticosteroids
- cyclosporin
- epoetin, darbepoetin
- hormone replacement therapy
- irreversible MAO inhibitors (phenelzine, tranylcypromine)†
- leflunomide
- moclobemide (rare)
- nicotine (infrequent)
- NSAIDs/COX–2 selective NSAIDs
- oral contraceptives
- sibutramine
- sympathomimetics/oral decongestants (rare)
- tacrolimus
- venlafaxine (dose related)

Complementary medicines that may increase blood pressure

Listed below are some of the more commonly encountered complementary medicines that have clinical reports of increasing BP.[8]

- American mistletoe
- Angel's trumpet
- Butcher's Broom
- Caffeine-containing herbs (guarana, black tea, cola nut, green tea, maté)
- DHEA (dehydroepiandrosterone)
- Ginger
- Ginseng, panax
- Ginseng, Siberian
- Guarana
- Hawaiian baby woodrose
- Jimson weed
- Liquorice
- Maté
- Melatonin
- Peyote
- Phenylalanine
- Sage
- St John's wort
- Yohimbine

For more information see www.nps.org.au/healthpro, click on the Topics and resources tab, and follow Products then Health professional tools then Complementary medicines which may increase blood pressure.

* Abrupt withdrawal may lead to rebound hypertension.

† Monoamine oxidase inhibitors in combination with tyramine-rich foods (e.g. matured or out of date cheese, fermented or matured meats, yeast and soy bean extracts, and others) can lead to hypertensive crisis.

Blood pressure monitoring and control

Any movement towards the target BP and cardiovascular risk-factor modification will be beneficial, particularly in people at high cardiovascular risk. It is important to individualise the aims of treatment.[9] Target BP levels may not be achieved or tolerated in some patients, especially the elderly.[10] However, target levels in patients with diabetes are particularly important: tight control of BP reduces the risk of microvascular and macrovascular diabetic complications.[11] Recommended monitoring of BP in patients with diabetes is every 4 months.[12]

Self-measurement of BP should be encouraged to provide the patient with better understanding of their BP and help them be more actively involved in their management (www.heartfoundation.com.au).

Target blood pressure levels

- **Below 140/90 mmHg:**[9,13] for people ≥ 65 years, unless they have diabetes and/or renal impairment, and/or proteinuria > 0.25 g/day.
- **Below 130/85**[6,9,10,13] **or 130/80 mmHg:**[12,14,15] for people < 65 years, or those with diabetes and/or those with renal impairment, and/or proteinuria 0.25–1 g/day.
- **Below 125/75 mmHg:**[9,13,15] for people with proteinuria > 1 g/day (i.e. people with and without diabetes).

Counselling

The Professional Practice Standards[1] state that 'the pharmacist ensures that the consumer has sufficient knowledge of their medicines to facilitate their safe and effective use'. This is achieved by:

- offering counselling by a pharmacist to all consumers
- providing counselling according to the needs of the consumer
- the pharmacist being the person responsible for counselling consumers about prescription medicines
- providing written information when available, to supplement verbal counselling
- systematically recording counselling events that the pharmacist considers clinically important
- supporting the counselling provided by the pharmacist with evidence-based information.

Certain triggers identify patients as having a high priority for counselling (see audit form Q12). However, counselling should always be tailored to the individual needs of the patient.

Counselling (cont'd)

Counselling points covered in the audit form include:

- **Purpose** – explain why it is important to control BP. The only way to find out if BP is high is by checking it regularly. High BP usually does not give warning signs, and the patient often feels perfectly well.

  Possible complications of high blood pressure:
  - heart attack
  - stroke
  - heart failure
  - kidney disease.

  Risks of complications are increased by:
  - smoking
  - high blood cholesterol
  - overweight
  - diabetes.

- **Lifestyle advice** – each lifestyle intervention has the potential to reduce BP equivalent to that of 1 standard dose of antihypertensive agent in appropriately selected patients.[6]

  Encourage the patient to:
  - be a non-smoker (for information on quitting smoking call the Quitline 131 848)
  - reduce salt intake
  - achieve and maintain a healthy body weight
  - limit alcohol intake: no more than 2 drinks per day (men), or 1 drink per day (women)
  - undertake regular physical activity.

  Some exercises should be avoided by people with high BP e.g. body presses and lifting weights.
- **How to take oral antihypertensive drug(s)** – advise patients that it is important to take any antihypertensive medicines exactly as prescribed and not to stop or change it unless advised to do so by their doctor.
- **Response to therapy** – routinely check progress with management. Stress the need for ongoing monitoring of BP and encourage self-measurement when appropriate. Advise those who self-monitor to do so under the same conditions about the same time of the day and in the same manner each time, e.g. sitting comfortably for 5 minutes after breakfast and then record the measurement.
- **Adverse effects** – when starting a new antihypertensive agent discuss the potential for adverse effects and how to minimise them. If the patient has used the agent(s) before, ask about presence of adverse effects.
- **Interactions** – remind patients always to check with their doctor or pharmacist before taking any other medicines, including complementary medicines (see page 3).
- **Referral** – consider providing a written referral with specific details of the reason for referral and suggestions for management when appropriate (as recommended in Standard 2, Policy P2I of the QCPP standards).

  Referral to other healthcare professionals for lifestyle advice may also be appropriate.

Useful resources

- Refer patients to www.heartfoundation.com.au or www.health.gov.au for a range of patient leaflets on BP and lifestyle modifications.
- Refer those ready to quit smoking, or who have begun the quitting process, to Quitline (131 848) for support.
- Offer Pharmacy Self Care Health Information cards from the PSA, if available.

Providing written information

Consumer medicine information (CMI) can be used to supplement verbal counselling.[1] CMIs may be offered to the patient each time a product is dispensed.[16] Whether this is appropriate is a matter for professional judgement.

CMIs should generally be provided:
- when a medicine is first provided to the patient
- on provision of a medicine when:
  - a significant change to the CMI has been notified by a sponsor (medicine manufacturer)
  - the dosage form has been changed (e.g. to a once-daily formulation)
  - brand substitution occurs and providing the CMI is deemed appropriate
- with each supply of a medicine for which there are valid reasons for regular reinforcement of information
- at the patient's/carer's request
- when the patient has special needs
- at regular intervals for medicines used for long-term therapy (e.g. every 6 months).

Total counselling time

Counselling provided to the patient or their agent should be done in a way that is sensitive to privacy and confidentiality to encourage full discussion.

Summary of planned actions

Identify any further actions that need to be implemented for the patient.

Use the *Action plan* enclosed to detail any planned actions for individual patients that you may wish to refer to during their next episode of care. You may prefer to use patient records or specific documentation that you already use.

Table 1. Specific considerations for patients with coexisting conditions

Coexisting conditions/ characteristics	Potentially favourable effects	Potentially unfavourable effects	
		Contraindications	Precautions
Angina	Beta blockers, calcium-channel blockers		Calcium-channel blockers (on initiation or withdrawal)
Asthma/COPD		Beta blockers (except cardioselective agents, e.g. atenolol, metoprolol)	Cardioselective beta blockers, e.g. atenolol, metoprolol (use cautiously in mild/moderate disease)
Benign prostatic hypertrophy	Alpha blockers		
Bilateral renal artery stenosis (or unilateral with 1 kidney)		ACE inhibitors, angiotensin II-receptor antagonists	
Bradycardia (severe), grade 2 or 3 atrioventricular block		Beta blockers, calcium-channel blockers	
Diabetes mellitus – without renal disease	ACE inhibitors, angiotensin II-receptor antagonists*, beta blockers, low-dose thiazides or thiazide-like diuretics		
– with microalbuminuria/ proteinuria	ACE inhibitors, angiotensin II-receptor antagonists		
Elderly	Calcium-channel blockers, low-dose thiazides or thiazide-like diuretics		Beta blockers (generally less effective), calcium-channel blockers, thiazides or thiazide-like diuretics (increased risk of electrolyte imbalance)
Gout			Thiazides or thiazide-like diuretics
Heart failure	ACE inhibitors, angiotensin II-receptor antagonists*, beta blockers (i.e. bisoprolol, carvedilol, metoprolol CR), low-dose thiazides or thiazide-like diuretics	Alpha blockers in heart failure due to mechanical obstruction e.g. aortic stenosis; beta blockers in uncontrolled heart failure	Calcium-channel blockers (especially verapamil, diltiazem)
Hyperkalaemia		ACE inhibitors, angiotensin II-receptor antagonists	
Isolated systolic hypertension	Calcium-channel blockers, low-dose thiazides or thiazide-like diuretics		
Myocardial infarction (post)	ACE inhibitors, beta blockers		
Non-diabetic nephropathy	ACE inhibitors		
Orthostatic hypotension			Alpha blockers (in volume depletion and the elderly), thiazides or thiazide-like diuretics (when symptomatic)
Peripheral vascular disease			Beta blockers
Pregnancy	Refer to *Australian Medicines Handbook* and *Therapeutic Guidelines: Cardiovascular*		
Renal impairment	Refer to *Australian Medicines Handbook*		
Secondary stroke prevention	Low-dose thiazides or thiazide-like diuretics ± ACE inhibitors		
Tachyarrhythmias	Beta blockers		

* Consider using an angiotensin II-receptor antagonist when there is a documented ACE inhibitor intolerance.

For more detailed information about the above drugs, refer to *Australian Medicines Handbook* 2007 and the approved product information for the drug. Further information can be obtained from TAIS on 1300 138 677.

Developed from:

- Australian Medicines Handbook, 2007.
- Therapeutic Guidelines: Cardiovascular. Version 4, 2004.
- Hypertension management guide for doctors. National Heart Foundation of Australia, 2004.
- World Health Organization, International Society of Hypertension Writing Group. 2003 WHO International Society of Hypertension (ISH) statement on management of hypertension. J Hypertens 2003;21:1983–92.
- National Institutes of Health, National Heart, Lung and Blood Institutes. The seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure. NIH, 2004. (accessed 15 January 2007).
- Prodigy Guidance. Hypertension. Prodigy, 2007. http://www.cks.library.nhs.uk/hypertension (accessed 13 February 2007).
- Prodigy Guidance. Diabetes type 1 and 2 - hypertension. Prodigy, 2007. http://www.cks.library.nhs.uk /diabetes_hypertension (accessed 13 February 2007).
- Lip G, Sudlow RP. Stroke prevention. BMJ Clinical Evidence, 2006. (accessed 14 February 2007).

Pharmacist competencies

Participation in this Pharmacy practice audit may help you to address the following competencies.[17]

Functional Area	Competency Unit
1: Practice pharmacy in a professional and ethical manner	1.1: Practise legally 1.2: Practise to accepted standards 1.3: Pursue lifelong professional learning and contribute to the development of others
3: Promote and contribute to optimal use of medicines	3.1: Participate in therapeutic decision making 3.2: Provide ongoing pharmaceutical management
4: Dispense medicines	4.2: Evaluate prescribed medicines 4.3: Supply prescribed medicines (element 3)
7: Provide medicines and health information and education	7.3: Disseminate information (elements 2 and 3)
8: Apply organisational skills in the practice of pharmacy	8.1: Plan and manage work time 8.6: Plan and manage pharmacy services and the work environment (elements 1 and 3)

Confidentiality and privacy

What will happen to your patient data

- Your de-identified patient data forms are scanned and returned to you.
- Your individual results are kept confidential and are provided to you only.
- Your data are aggregated with those of other participants and the aggregate results (which do not identify any individual patient or pharmacist):
  - are provided to all participants
  - may be used in NPS evaluation and reports.

At the close of the audit cycle (i.e. after individual results are returned to participants), all potentially identifying data are removed from NPS records. Your individual audit results will then no longer be available.

What will happen to your personal details

Your personal details are:

- provided to a mail house for processing
- recorded for NPS evaluation
- provided to the Pharmaceutical Society of Australia for CPD & PI credit point allocation, if appropriate
- provided to your pre-registration course co-ordinator to confirm completion, if appropriate
- available from NPS by request in writing.

Please note: You are responsible for advising NPS of any changes of address during the audit cycle.

Further information

Therapeutic enquiries
Contact Clare Bottomley or Sheena O'Riordan
Phone (02) 8217 8700

References

1. Pharmaceutical Society of Australia. Professional Practice Standards, Version 3, December 2005. Canberra: Pharmaceutical Society of Australia, 2006.
2. Pharmaceutical Society of Australia. Essential CPE: Medication Adherence. Canberra: Pharmaceutical Society of Australia, 2006.
3. Schroeder K, Fahey T, Ebrahim S. Interventions for improving adherence to treatment in patients with high blood pressure in ambulatory settings. Cochrane Database Syst Rev. 2004;(2):CD004804.
4. Morisky D, et al. Concurrent and predictive validity of a self-reported measure of medication adherence. Medical Care 1986;24:67–74.
5. Nelson M, et al. Self-reported adherence with medication and cardiovascular disease outcomes in the Secondary Australian National Blood Pressure Study (ANBP2). Med J Aust 2006;185:487–9.
6. Australian Medicines Handbook, 2007.
7. Aronson JK, ed. Meyler's side effects of drugs. The International Encyclopedia of Adverse Drug Reactions and Interactions. 15th edn. Amsterdam: Elsevier, 2006.
8. NPS Therapeutic Advice and Information Service. Advice provided, March 2007.
9. Hypertension management guide for doctors. National Heart Foundation of Australia, 2004.
10. Therapeutic Guidelines: Cardiovascular, Version 4. Melbourne: Therapeutic Guidelines Ltd, 2003.
11. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. BMJ 1998;317:703-13. Erratum in: BMJ 1999;318:29.
12. Harris P, et al. Diabetes management in general practice 2005/6. 11th edn: Diabetes Australia, 2005/6.
13. National Heart Foundation of Australia (NHF) and Cardiac Society of Australia and New Zealand. Reducing risk in heart disease: Guidelines for preventing cardiovascular events in people with coronary heart disease. NHF, 2003.
14. Therapeutic Guidelines: Endocrinology. Version 3. Melbourne: Therapeutic Guidelines Ltd, 2003.
15. National Health and Medical Research Council. National evidence based guidelines for management of type 2 diabetes mellitus: blood pressure control. Endorsed by NHMRC, March 2004.
16. Pharmaceutical Society of Australia. Consumer Medicine Information and the pharmacist – Guidelines for pharmacists. Canberra: Pharmaceutical Society of Australia, 2007.
17. Pharmaceutical Society of Australia. Competency standards for pharmacists in Australia 2003. Canberra: Pharmaceutical Society of Australia, 2003.

April 2007

The information contained in this material is derived from a critical analysis of a wide range of authoritative evidence.
Any treatment decisions based on this information should be made in the context of the clinical circumstances of each patient.

National Prescribing Service Limited

NPSA0413

National Prescribing Service Limited ACN 082 034 393
An independent, non-profit organisation for Quality Use of Medicines, funded by the Australian Government Department of Health and Ageing.

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National Prescribing Service Limited

Some clinical information may not be available in all practice settings. Respond as appropriate with the information available.

- Use a black biro to make a cross (X) in the box for your response.
- If you make a mistake, use white correction fluid.

NPS office use only

Episode of care and antihypertensive medicines

1. What was your practice setting for this episode of care?

☐ community pharmacy ☐ medication review, e.g. HMR/RMMR ☐ hospital pharmacy ☐ other _____

2a. Who was involved in this episode of care?

☐ the patient ☐ relative/carer/support person ☐ other _____

AND

☐ pharmacist ☐ pre-registration pharmacist

2b. Characteristics of person involved that may affect this episode of care:

☐ none ☐ poor hearing ☐ language difficulties ☐ cognitive impairment ☐ poor eye sight ☐ other _____

3. Age of patient:

☐ < 65 years ☐ ≥ 65 years

4. Current antihypertensive agent(s): (mark all that apply)

Single agents

☐ angiotensin-converting enzyme (ACE) inhibitor ☐ angiotensin II-receptor antagonist ☐ beta blocker

☐ calcium-channel blocker ☐ thiazide/thiazide-like diuretic ☐ other _____

Fixed-dose combination products

☐ ACE inhibitor/thiazide ☐ angiotensin II-receptor antagonist/thiazide ☐ calcium-channel blocker/ACE inhibitor ☐ calcium-channel blocker/statin

5. Was the antihypertensive agent(s): (mark all that apply)

☐ the first ever antihypertensive medicine used → Ensure understanding of purpose and possible adverse effects of antihypertensive treatment.

☐ ongoing therapy for hypertension → Consider reinforcing 1 or 2 points from previous counselling.

☐ an addition or change to ongoing therapy → Ensure understanding of how to take, and response to, antihypertensive treatment.

☐ not determined → Consider checking medication records to prioritise patients for counselling in future.

Adherence to antihypertensive medicines

6. When was the last prescription for antihypertensive agent(s) dispensed:

☐ not applicable (first dispensing) ☐ < 4 weeks ago ☐ 4–6 weeks ago ☐ **> 6 weeks ago** ▼

Did you check your computer records to monitor adherence?

☐ not applicable ☐ yes ☐ no → Regularly check dispensing records to monitor adherence

Ask your patients ….

How often do you forget to take your medicines? (See Guide, page 2)

7. Was the patient adherent to their antihypertensive medicines?

☐ not applicable (first dispensing) ☐ not determined ☐ yes ☐ no → Consider strategies to assist adherence

Relevant coexisting conditions/characteristics and other medicines

8. Relevant coexisting conditions/characteristics: (see Guide, Table 1)

☐ not known ☐ none

☐ cardiovascular disease (excluding hypertension)
(specify) _____

☐ diabetes
(specify) _____

☐ renal disease
(specify) _____

☐ respiratory disease
(specify) _____

☐ other relevant problems
(specify) _____

9. Is there a more appropriate antihypertensive agent that may have a more favourable effect on coexisting conditions? (See Guide, Table 1)

☐ yes → ☐ no → Consider contacting or referral to prescriber

☐ not known ☐ information not available

10. Was the patient using any medicines that may increase blood pressure (prescribed, OTC or complementary)? (See Guide, page 2)

☐ yes → ☐ no → Consider contacting or referral to prescriber

☐ not known ☐ information not available

Please turn over to continue

Blood pressure monitoring and control

11. Did you initiate a discussion about blood pressure control?

☐ **yes** ▼ ☐ no

Did you discuss… (mark all that apply)

- ☐ if BP was moving towards target
- ☐ how the most recent BP measurement compared with previous measurements
- ☐ if doctor was happy with BP control
- ☐ not able/willing to discuss

Notes on discussion:

_____

_____

If BP is not improving

Encourage adherence to medicines.

Discuss benefits of ongoing BP monitoring.

Any movement towards target BP is beneficial.

Patients with diabetes: monitor BP every 4 months.

Recommended target BP

- < 140/90 mmHg: ≥ 65 years
- < 130/85 or 130/80 mmHg: < 65 years or with diabetes and/or renal impairment and/or proteinuria 0.25–1 g/day
- < 125/75 mmHg: proteinuria > 1 g/day

Counselling

12. Triggers for counselling:

- ☐ using an antihypertensive agent for the first time
- ☐ recent changes to antihypertensive agent(s)
- ☐ apparent confusion regarding antihypertensive medicines
- ☐ apparent lack of knowledge of hypertension and its consequences
- ☐ problems with adherence
- ☐ overweight/obese
- ☐ a smoker

High priority for counselling

Consider gathering information about the patient and checking medication records to prioritise patients for counselling in future.

Carer support may be required for patients with cognitive impairment.

13. What verbal counselling was provided at this episode of care?

☐ purpose of antihypertensive medicines	Explain importance of BP control and prevention of long-term complications.
☐ how to take oral antihypertensive medicines	Provide details on dose and timing to optimise adherence.
☐ possible adverse effects of medicines	Provide advice on potential for adverse effects when starting a new antihypertensive agent. Ask about presence of adverse effects with ongoing prescriptions.
☐ response to therapy	Stress the need for ongoing monitoring of BP to assess response to therapy. Encourage self-monitoring when appropriate.
☐ lifestyle advice ☐ alcohol reduction ☐ diet ☐ exercise ☐ salt reduction ☐ smoking cessation ☐ weight loss	Lifelong lifestyle modifications are vital. Actively promote lifestyle modifications when appropriate. Consider referral to other healthcare professionals.
☐ strategies to assist adherence to medicines	Recommend use of calendars or diaries as reminders, or blister packs or dosette boxes when appropriate. Rationalise dosing times or suggest once-daily dosing regimens, to the prescriber when appropriate.
☐ potential interactions with other medicines	Remind patients always to check with their doctor or pharmacist before taking any new medicines (prescribed, OTC or complementary medicines).
☐ cardiovascular risk assessment	Determine cardiovascular risk to demonstrate benefits of lifestyle interventions and/or treatment (see the New Zealand Cardiovascular Risk Calculator, enclosed).
☐ no verbal counselling provided	Consider reinforcing 1 or 2 points for ongoing therapy. Offer written material if verbal counselling is not able to be given.

14. What written material was supplied to support verbal counselling?

☐ none ☐ consumer medicine information (CMI) leaflet on antihypertensive agent(s) ☐ CMI for other medicines

☐ patient medication list ☐ Self Care card ☐ other _____

15. Approximate time for counselling on hypertension management:

☐ no counselling given ☐ < 2 minutes ☐ 2–5 minutes ☐ 6–10 minutes ☐ > 10 minutes

Summary of planned actions

16. Mark any further actions to be implemented for this patient:

- ☐ contact prescriber directly to discuss management
- ☐ refer to prescriber for review
- ☐ refer to other healthcare professional for lifestyle advice
- ☐ refer for HMR/RMMR
- ☐ provide specific counselling or resources at next episode of care
- ☐ check adherence at next episode of care
- ☐ recommend/offer blood pressure monitoring at next episode of care
- ☐ contact carer/relative/support person
- ☐ other _____

Consider recording specific details of further actions on *Action plan* for future reference

Notes:

_____

_____

_____

_____