Improving medication management of palliative care patients:

Enhancing the role of community pharmacists

VOLUME 2: APPENDICES

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Dr Julia A. Fleming
Dr Simon Wein
Dr Maria Pisasale
Mr W.J. (Bill) Scott

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ACKNOWLEDGEMENTS

We would like to thank the Australian Government Department of Health and Ageing for financially supporting this research project, as part of the Third Community Pharmacy Agreement with the Pharmacy Guild of Australia.

Our thanks also go to those people: the pharmacists, patients, carers, doctors, and nurses, who gave their time and energy to participate in various stages of this project; without whom this research would not have been possible.

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Report prepared by:

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TABLE OF CONTENTS
Table of Contents

ACKNOWLEDGEMENTS ............................................................................................................ 2

APPENDIX A: OVERVIEW OF CHANGES TO THE STUDY METHODOLOGY.................................. 10

APPENDIX B: MAJOR PALLIATIVE CANCER CARE TOPICS AND EDUCATIONAL TOPICS IDENTIFIED TO INFORM THE LITERATURE SEARCH STRATEGY ................................................................................. 11

APPENDIX C: CONTENTS OF THE LITERATURE REVIEW ................................................................ 12

APPENDIX D: QUESTIONNAIRE FOR COMMUNITY PHARMACISTS .................................................. 13

APPENDIX E: LETTER OF INVITATION TO COMMUNITY PHARMACISTS TO PARTICIPATE IN A POSTAL SURVEY .......................................................................................................................... 17

APPENDIX F: EXPLANATORY STATEMENT FOR COMMUNITY PHARMACISTS COMPLETING POSTAL SURVEY .. 18

APPENDIX G: SURVEY PHARMACISTS – REGISTERING INTEREST TO PARTICIPATE IN THE ONLINE EDUCATIONAL PROGRAM .......................................................................................... 20

APPENDIX H: PHARMACISTS’ SURVEY: ADDITIONAL RESPONSES ..................................................... 21

APPENDIX I: EXPLANATORY STATEMENT FOR NOMINAL GROUP PARTICIPANTS .................................. 25

APPENDIX J: CONSENT FORM FOR NOMINAL GROUP PARTICIPANTS ................................................. 27

APPENDIX K: DEVELOPMENT OF THE NOMINAL GROUP QUESTIONS ................................................ 28

APPENDIX L: INFORMATION GIVEN TO NOMINAL GROUP PARTICIPANTS IN PREPARATION FOR GROUP MEETINGS ............................................................................................................. 29


APPENDIX N: RESULTS OF THE NOMINAL GROUP PROCESS THAT WERE SENT TO THE PARTICIPANTS FOR VALIDATION .............................................................................................................. 36

APPENDIX O: THE GROUPS’ DECISION PHASE: NOMINAL GROUPS’ ORDER OF PRIORITY OF MODULES ........... 65

APPENDIX P: MODULE Writers GUIDELINES ..................................................................................... 67

APPENDIX Q: LETTER OF INVITATION TO THE EDUCATIONAL GROUP PHARMACISTS REGARDING THE EDUCATIONAL PROGRAM ......................................................................................... 96

APPENDIX R: EXPLANATORY STATEMENT FOR THE PHARMACISTS UNDERTAKING THE EDUCATIONAL PROGRAM .................................................................................................................. 97

APPENDIX S: CONSENT FORM FOR THE PHARMACISTS UNDERTAKING THE EDUCATIONAL PROGRAM ........ 100

APPENDIX T: LETTER OF WELCOME AND INSTRUCTIONS FOR THE PHARMACISTS UNDERTAKING THE EDUCATIONAL PROGRAM ............................................................................................... 101

APPENDIX U: PRE-KNOWLEDGE QUESTIONNAIRE .............................................................................. 107

APPENDIX V: CD-ROM INSTRUCTIONS, SUGGESTED TIMELINES AND CREDIT POINTS FOR COMPLETION OF THE PROGRAM ........................................................................................................... 113
# Table of contents

APPENDIX W: PHARMACISTS AND PALLIATIVE CARE PROGRAM - EVIDENCE FOR COMPLETION OF THE MODULES ........................................................................................................................................... 115

APPENDIX X: MODERATOR’S GUIDELINES .................................................................................................................................................................................. 116

APPENDIX Y: PHARMACISTS’ TRAINING MANUAL: DOCUMENTING INTERVENTIONS, INCLUDING EXPERT REVIEW PANEL ASSESSMENT FORMS .................................................................................................................. 135

APPENDIX Z: POST-KNOWLEDGE QUESTIONNAIRE .................................................................................................................. 164

APPENDIX AA: 3-MONTH POST-KNOWLEDGE AND POST-PROGRAM QUESTIONNAIRE .................................................................................................................. 169

APPENDIX AB: POST PROGRAM EVALUATION QUESTIONNAIRE .................................................................................................................. 174

APPENDIX AC: PATIENT/CARER QUESTIONNAIRE .................................................................................................................. 181

APPENDIX AD: LETTER OF INVITATION (EVALUATION GROUP PHARMACISTS) .................................................................................................................. 189

APPENDIX AE: EXPLANATORY STATEMENT (EVALUATION GROUP PHARMACISTS) .................................................................................................................. 190

APPENDIX AF: INFORMED CONSENT (EVALUATION GROUP PHARMACISTS) .................................................................................................................. 193

APPENDIX AG: REVOCATION OF CONSENT FORM (EVALUATION GROUP PHARMACISTS) .................................................................................................................. 195

APPENDIX AH: MAJOR CHANGES MADE TO ORIGINAL D.O.C.U.M.E.N.T. TOOL .................................................................................................................. 196

APPENDIX AJ: MARKING GUIDE – PRE-KNOWLEDGE QUESTIONNAIRE .................................................................................................................. 197

APPENDIX AJ: POST-PROGRAM EVALUATION QUESTIONNAIRE: ADDITIONAL COMMENTS .................................................................................................................. 203

APPENDIX AK: 3-MONTH POST-KNOWLEDGE QUESTIONNAIRE, QUESTION 16: REFLECTIONS ABOUT THE PROGRAM AND HOW IT MAY HAVE IMPACTED ON THE PARTICIPANTS’ PHARMACY PRACTICE .................................................................................................................. 214

APPENDIX AL: DESCRIPTIVE ANALYSIS OF PRE-PROGRAM INTERVENTIONS .................................................................................................................. 218

APPENDIX AM: DESCRIPTIVE ANALYSIS OF DURING-PROGRAM INTERVENTIONS .................................................................................................................. 220

APPENDIX AN: EXPERT REVIEW PANEL’S ASSESSMENT OF PHARMACISTS’ INTERVENTIONS .................................................................................................................. 221

APPENDIX AO: INTERVENTIONS IDENTIFIED BY THE EXPERT REVIEW PANEL FOR WHICH THERE WAS INSUFFICIENT DETAIL AVAILABLE – ISSUES AND RESOLUTIONS .................................................................................................................. 229

APPENDIX AP: PARTICIPANTS’ MEDICATION KNOWLEDGE AND RECALL OF MEDICAL INFORMATION .................................................................................................................. 231

APPENDIX AQ: PARTICIPANTS’ VIEW OF THEIR INTERACTION WITH THE PHARMACIST .................................................................................................................. 233

APPENDIX AR: ADDITIONAL COMMENTS MADE BY PARTICIPANTS .................................................................................................................. 235

APPENDIX AS: INTERVENTIONS MADE BY PHARMACISTS WITH PATIENTS/CARERS WHO COMPLETED THE QUESTIONNAIRES .................................................................................................................. 236

APPENDIX AT: WAS THE PROGRAM BENEFICIAL? .................................................................................................................. 237

APPENDIX AU: DID THE WEB SITE ASSIST PHARMACISTS’ LEARNING? .................................................................................................................. 239

APPENDIX AV: ENGAGEMENT WITH THE PROGRAM MATERIAL – SUBJECT FORMAT .................................................................................................................. 241

APPENDIX AW: PROGRAM DESIGN ASPECTS ASSISTING ENGAGEMENT WITH THE MATERIAL .................................................................................................................. 243
Table of contents

APPENDIX AX: INTERACTIVE ACTIVITIES................................................................................................................................. 245

APPENDIX AY: WHICH MODULES WERE USEFUL AND WHICH WERE NOT? ........................................................................... 247

APPENDIX AZ: DID PHARMACISTS’ CONSULTATION WITH OTHERS INCREASE FROM DOING THE PROGRAM? ... 249

Please note: For Executive Summary and Report of this project, refer to Volume 1.
APPENDICES
# APPENDIX A: Overview of changes to the study methodology

<table>
<thead>
<tr>
<th>Overview of the methods: original proposal</th>
<th>Changes to original proposal *</th>
</tr>
</thead>
</table>
| **Stage 1:** Identification of educational needs of community pharmacists in palliative cancer care  
  a) Literature review  
  b) Interviews with key stakeholders  
  c) Focus groups with key stakeholders  | **Stage 1:** Identification of educational needs of community pharmacists in palliative cancer care  
  a) Literature review  
  b) *Survey of metropolitan and rural community Australian pharmacists. (Refer Section 3.1.2)  
  c) *Nominal groups with key stakeholders. (Refer Section 3.1.3)  |
| **Stage 2:** Development, review and delivery of educational components | **Stage 2:** Development, review and delivery of educational components |
| **Stage 3:** Implementation trial and data collection  
  a) Impact on palliative care patients  
    • Structured questionnaire to evaluate medication knowledge and attitudes  
    • Questionnaire to determine any effects on patient/carer interaction with their community pharmacist  
    • Documentation and assessment of interventions  
    • Assessment of medication-related problems  
  b) Impact on community pharmacists  
    • Multiple-choice, problem-based, questionnaire to assess level of knowledge before, immediately after and again 4 months after completion of the educational program  
    • Exit questionnaire and again at 4 months to determine pharmacists’ satisfaction with education program  
  c) Impact on providers of palliative care services  
    • Questionnaire  | **Stage 3:** Implementation trial and data collection  
  a) Impact on palliative care patients  
    • *Structured questionnaire to evaluate medication knowledge, attitudes and to determine any effects on patient/carer interaction with their community pharmacist. (Refer Section 3.3.5)  
    • *Documentation and assessment of interventions, including assessment of medication-related problems. (Refer Section 3.3.4)  
  b) Impact on community pharmacists  
    • *Multiple-choice, problem-based, questionnaire to assess level of knowledge before, immediately after and again 3* months after completion of the educational program. (Refer Section 3.3.6)  
    • *Program Evaluation questionnaire at completion and again at 3* months to determine pharmacists’ satisfaction with education program. (Refer Section 3.3.7)  
  c) Impact on providers of palliative care services  
    • *Unable to be carried out. (Section 6.2)  |
## Appendix B: Major palliative cancer care topics and educational topics identified to inform the literature search strategy

<table>
<thead>
<tr>
<th>Major palliative care topics</th>
<th>Search engine/database(s) used</th>
<th>Key words used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction to palliative care</strong>, (including definition of palliative care, principles of palliative care, delivery of palliative care by the palliative care team)</td>
<td>Cinahl via Ovid 1982 - Google</td>
<td>Palliative care, terminal care, ambulatory care, pharmaceutical care, community pharmacists, community pharmacy, pharmacist, pharmacy, cancer, cancer patients</td>
</tr>
<tr>
<td><strong>Symptom management in palliative care</strong> (including both non-pain symptoms and pain)</td>
<td>Ingenta Journals</td>
<td>Palliative care, terminal care, cancer, cancer care, symptoms, symptom management, common symptoms, alimentary symptoms (e.g. constipation, diarrhoea), respiratory symptoms (e.g. cough), neuropsychological symptoms (e.g. delirium), pain, genitourinary, skin, metabolic, endocrine, haematological</td>
</tr>
<tr>
<td><strong>Complementary and alternative medicines used by patients with cancer</strong> (including drug interactions between complementary and alternative medicines and orthodox medicines/treatments)</td>
<td>Cinahl via Ovid 1982 - Cancer.org Memorial Sloan-Kettering Cancer Center Google</td>
<td>Complementary medicines, alternative medicines, cancer, oncology, chemotherapy, herb-drug interactions, vitamins, herbs, herbal medicines</td>
</tr>
<tr>
<td><strong>Drug delivery devices and approaches used in palliative care</strong> (including drug interactions in syringe drivers)</td>
<td>Cinahl via Ovid 1982 - Google</td>
<td>Delivery devices, devices, palliative care, cancer, enteral nutrition, parenteral nutrition, enteral tube feeding, transcutaneous electrical nerve stimulation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major educational topics</th>
<th>Search engine/database(s) used</th>
<th>Key words used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The educational needs of community pharmacists and other health professionals in palliative care</strong></td>
<td>Cinahl via Ovid 1982 - Blackwell Synergy</td>
<td>Knowledge, attitudes, beliefs, education needs, palliative care, terminal care, consumers, patients, palliative care patients, cancer patients, families, caregivers, doctors, physicians, nurses, pharmacists, nursing students, medical students, pharmacy students</td>
</tr>
<tr>
<td><strong>Principles of adult learning</strong></td>
<td>Cinahl via Ovid 1982 - Eric Google</td>
<td>Adult learning, adult learning theory/theories, learning, teaching adults, andragogy, Knowled, reflection</td>
</tr>
<tr>
<td><strong>Palliative care educational programs developed for various health professionals</strong> (including their implementation and evaluation)</td>
<td>Cinahl via Ovid 1982 - Blackwell Synergy</td>
<td>Education programs, palliative care, terminal care, cancer care, cancer, patients, health professionals, doctors, physicians, nurses, pharmacists, nursing students, medical students, pharmacy students, didactic, experiential, online, telephone, videoconference, workshops</td>
</tr>
</tbody>
</table>
## APPENDIX C: Contents of the literature review

<table>
<thead>
<tr>
<th>Seven major topics that informed the literature review strategy</th>
<th>Sub-headings/topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Palliative Care: Introduction</td>
<td>WHO’s Past and Present Definitions of Palliative Care</td>
</tr>
<tr>
<td></td>
<td>Palliative Care in Australia</td>
</tr>
<tr>
<td></td>
<td>The Role of Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Barriers to Effective Palliative Care</td>
</tr>
<tr>
<td>2. Palliative Care: Knowledge, Attitudes, Beliefs and Education Needs</td>
<td>Consumers (Patients, Families and/or Carers)</td>
</tr>
<tr>
<td></td>
<td>Doctors and Nurses</td>
</tr>
<tr>
<td></td>
<td>Undergraduate Medical and Nursing Students</td>
</tr>
<tr>
<td></td>
<td>Pharmacists</td>
</tr>
<tr>
<td></td>
<td>Undergraduate Pharmacy Students</td>
</tr>
<tr>
<td>3. Adult Learning: Application to Palliative Care Learning</td>
<td>Adult Learning Principles</td>
</tr>
<tr>
<td></td>
<td>The Role of the Andragogical</td>
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<tr>
<td></td>
<td>Teacher/Facilitator/Educator</td>
</tr>
<tr>
<td></td>
<td>Adult Learning Styles and the Experiential Learning Cycle</td>
</tr>
<tr>
<td></td>
<td>The Importance of Critical Reflection in Learning Education Program Design: In Context of Palliative Care</td>
</tr>
<tr>
<td>4. Palliative Care Education Programs and Their Evaluation</td>
<td>Didactic (Consumers &amp; Health Professionals)</td>
</tr>
<tr>
<td></td>
<td>Experiential, Online, Telephone, Workshops, Videoconference, and Combined format (Undergraduate Students &amp; Health Care Professionals)</td>
</tr>
<tr>
<td>5. Oncology</td>
<td>Aetiology of Cancer</td>
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<tr>
<td></td>
<td>Epidemiology</td>
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<tr>
<td></td>
<td>Diagnosis and Staging</td>
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<tr>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>Common Toxicities/Symptoms and Their Management</td>
</tr>
<tr>
<td></td>
<td>(Common and Acute Toxicities [e.g. alimentary, respiratory, neuropsychological, pain, genitourinary, haematological, dermatological] and Specific Organ Toxicities [e.g. neurological, cardiac, pulmonary])</td>
</tr>
<tr>
<td></td>
<td>Long-term Complications of Chemotherapy</td>
</tr>
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<td></td>
<td>Treatment of Oncological Emergencies</td>
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<tr>
<td></td>
<td>Prevention</td>
</tr>
<tr>
<td></td>
<td>Solid Malignancies</td>
</tr>
<tr>
<td></td>
<td>Haematological Malignancies</td>
</tr>
<tr>
<td>6. Complementary and Alternative Medicine Use in Palliative Care: A Focus on Herbal Medicines</td>
<td>Definitions, Prevalence and Motivations</td>
</tr>
<tr>
<td></td>
<td>Alternative Medical Systems</td>
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<td></td>
<td>Mind-Body Interventions</td>
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<td></td>
<td>Manipulative and Body-Based Methods</td>
</tr>
<tr>
<td></td>
<td>Energy Therapies</td>
</tr>
<tr>
<td></td>
<td>Biologically Based Therapies (Diet &amp; Nutrition, Common Herbal Medicines used by Cancer Patients, Herbal Medicines: Interactions with Treatments [e.g. use with chemotherapy and anaesthesia], Counselling Cancer Patients about Herbal Medicines: The Role of the Pharmacist)</td>
</tr>
<tr>
<td>7. Approaches to Drug Delivery in Palliative Care</td>
<td>The Enteral Approach</td>
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<td></td>
<td>The Parenteral Approach</td>
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<tr>
<td></td>
<td>Subcutaneous Infusions</td>
</tr>
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<td></td>
<td>Transcutaneous Electrical Nerve Stimulation</td>
</tr>
</tbody>
</table>
APPENDIX D: Questionnaire for community pharmacists

PHARMACY GUILD APPROVAL NUMBER: 575

Safeera Hussainy
Victorian College of Pharmacy
Department of Pharmacy Practice
381 Royal Parade
Parkville, Victoria, 3052.
Ph: (03) 9903 9057

IMPROVING MEDICATION MANAGEMENT OF PALLIATIVE CARE PATIENTS:
ENHANCING THE ROLE OF COMMUNITY PHARMACISTS

This questionnaire will provide information about the educational needs of community pharmacists in palliative care related to cancer patients. It will assist in the development of an educational program to facilitate the role of community pharmacists in palliative cancer care.

Palliative care is the care of patients who have a progressive life-threatening illness, such as cancer.

The provision of palliative cancer care services by community pharmacists includes:

- the supply of prescription (e.g. morphine) and over-the-counter medications/products (e.g. saliva substitutes, wound dressings)
- the provision of evidence-based information related to palliative care medications
- the education of patients and/or their carers regarding the medication management of their condition
- the education of patients and/or their carers regarding the use of delivery devices used to administer medications (e.g. infusion pumps)

Please complete the following questions. Your responses will remain confidential.

SECTION 1- DEMOGRAPHICS

1. What is your gender?
   □ Male    □ Female

2. What will your age be on December 31, 2004?
   □ 21-29 years
   □ 30-39 years
   □ 40-49 years
   □ 50-59 years
   □ 60 years and over

3. What is the postcode of the pharmacy in which you work?

4. How many years have you been practising as a registered pharmacist?

   ____________ years
5. The following table lists a number of topics related to palliative cancer care that could 
be included in an online educational program developed for community pharmacists. 
Indicate the importance to you of learning more about each of the topics by ticking the 
appropriate boxes below.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Not important</th>
<th>Of some importance</th>
<th>Important</th>
<th>Very important</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles of Palliative Cancer Care</td>
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<tr>
<td>Causes of Cancer</td>
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<tr>
<td>Incidence and Prevalence of Cancer</td>
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<tr>
<td>Diagnosis and Staging of Cancer</td>
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<tr>
<td>Common Cancers: Risk Factors, Presentation, Treatments, Prognosis</td>
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<tr>
<td>e.g. breast, colon, lung and skin cancers</td>
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<tr>
<td>Management of Cancer Pain</td>
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<td>Management of Non-Pain Symptoms/Side Effects</td>
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<tr>
<td>e.g. constipation, nausea, pressure sores</td>
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<tr>
<td>Palliative Cancer Treatments</td>
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<td>e.g. chemotherapy, radiotherapy</td>
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<tr>
<td>Long Term Complications of Chemotherapy</td>
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<td>e.g. effects on fertility</td>
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<td>Handling of Cancer Emergencies</td>
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<td>e.g. hypercalcaemia, haemorrhage</td>
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<tr>
<td>Drug Interactions with Palliative Cancer Treatments</td>
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<td>Complementary and Alternative Medicines used by patients with cancer</td>
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<td>e.g. homeopathic and herbal medicines, transcutaneous electrical nerve stimulation</td>
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<tr>
<td>Methods of Drug Administration in Palliative Cancer Care</td>
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<tr>
<td>e.g. enteral and parenteral drug administration (nasogastric tubes, total parenteral nutrition), infusion pumps</td>
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<tr>
<td>Access to Palliative Cancer Medications</td>
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<tr>
<td>e.g. Pharmaceutical Benefits Scheme and Special Access Scheme “issues”</td>
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<tr>
<td>Psychosocial Care of patients</td>
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<tr>
<td>Communicating with patients and families</td>
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<tr>
<td>Terminology Used in Palliative Care</td>
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<tr>
<td>Conducting Medicine Reviews for patients (at home, in residential aged care facilities and hospices)</td>
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<tr>
<td>Other (please describe)</td>
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<tr>
<td>Other (please describe)</td>
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</tbody>
</table>
6. Indicate your level of knowledge of each of the following palliative cancer care topics by ticking the appropriate boxes in the table below.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Nil</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles of Palliative Cancer Care</td>
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<tr>
<td>Causes of Cancer</td>
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<tr>
<td>Common Cancers: Risk Factors, Presentation, Treatments, Prognosis</td>
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<tr>
<td>e.g. breast, colon, lung and skin cancers</td>
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<tr>
<td>Management of Cancer Pain</td>
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<td>Management of Non-Pain Symptoms/Side Effects</td>
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<td>e.g. constipation, nausea, pressure sores</td>
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<tr>
<td>Palliative Cancer Treatments</td>
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<td>e.g. chemotherapy, radiotherapy</td>
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<td>Long Term Complications of Chemotherapy</td>
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<td>e.g. effects on fertility</td>
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<td>Handling of Cancer Emergencies</td>
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<td>e.g. hypercalcaemia, haemorrhage</td>
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<tr>
<td>Drug Interactions with Palliative Cancer Treatments</td>
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<td>Complementary and Alternative Medicines used by patients with cancer</td>
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<td>e.g. homeopathic and herbal medicines, transcutaneous electrical nerve stimulation</td>
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<td>Methods of Drug Administration in Palliative Cancer Care</td>
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<td>e.g. enteral and parenteral drug administration (nasogastric tubes, total parenteral nutrition), infusion pumps</td>
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<tr>
<td>Access to Palliative Cancer Medications</td>
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<td>e.g. Pharmaceutical Benefits Scheme and Special Access Scheme “issues”</td>
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<td>Psychosocial Care of patients</td>
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<td>Communicating with patients and families</td>
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<td>Terminology Used in Palliative Care</td>
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<tr>
<td>Conducting Medicine Reviews for patients (at home, in residential aged care facilities and hospices)</td>
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<td>Other (please describe)</td>
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<tr>
<td>Other (please describe)</td>
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</table>
7. What format(s) would you find valuable to use in an online educational program in palliative cancer care? (You may tick more than one box)

☐ Information as text
*Information that can be read on screen or printed for easier reading or later reference.*

☐ Case studies
*You are presented with problem-based and pharmacy practice-relevant scenarios to solve. Answers are provided at the end for reflection. Case studies are used to support the information provided as text and to put problems into a clinical and pharmacy-relevant context.*

☐ Self-assessed multi-choice questionnaires
*You are presented with questions that have up to five possible answers, from which you can choose only one which is correct. Immediate feedback is given about the response you choose. This enables you to test your knowledge and understanding of topics.*

☐ Web-based Open discussion group
*You may post questions to, or information for, your peers. This allows you to discuss problems, share your experiences and provide practice-based solutions for each other.*

☐ Web-based Moderated discussion group
*As above for the open discussion group, and additionally your questions are answered by a qualified person who has expertise in the area.*

8. Would you participate in an online educational program for community pharmacists in palliative cancer care (that would be free of cost) if offered to you?

☐ Yes [go to question 9]
☐ No [please indicate why, and go to question 10]

9. If you would like to participate in the educational program that is developed to facilitate the role of community pharmacists in palliative cancer care, please write down your contact details on the separate slip provided with this questionnaire. Place the slip in one of the Reply Paid envelopes provided.

**SECTION 3 - OTHER**

10. a) Are there occasions when you deliver palliative cancer care advice/services? (Refer to examples of palliative cancer care services provided by community pharmacists on pg.1)

☐ Yes [go to question 10b] ☐ No [go to question 11]

10. b) How often do you deliver palliative cancer care advice/services?

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Less than monthly

11. Your comments are welcome.

Your contribution to this questionnaire is greatly appreciated. Please return your questionnaire in the Reply Paid envelope provided. If the envelope has been mislaid, please forward to:

Safeera Hussainy
Victorian College of Pharmacy, Department of Pharmacy Practice
381 Royal Parade, Parkville, Victoria, 3052

A copy of the Report compiled from this questionnaire will be sent to all participating pharmacists upon request.
APPENDIX E: Letter of Invitation to community pharmacists to participate in a postal survey

Attention: Mr. …

Dear Pharmacists

You are invited to contribute to the design of an online educational program in palliative cancer care for community pharmacists by completing the short questionnaire enclosed.

Following completion of the questionnaire, you will have the opportunity to participate in the free educational program.

Please read the Explanatory Statement provided. If you require further details contact Safeera Hussainy (ph: 03 9903 9057) or Jill Beattie (ph: 03 9903 9080).

Email: safeera.hussainy@vcp.monash.edu.au or jill.beattie@vcp.monash.edu.au
APPENDIX F: Explanatory Statement for community pharmacists completing postal survey

Explanatory Statement

Date: May 2004

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

About the Explanatory Statement
This Explanatory Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this Explanatory Statement carefully. Feel free to ask questions about any information in the document. Once you understand what the project is about and if you agree to take part in it, you will be asked to complete a questionnaire. By completing and submitting the questionnaire, you indicate that you understand the information, and that you give your consent to participate in the research project. You will be able to keep a copy of the Explanatory Statement for your record.

The Aim of the Research Project
The Pharmacy Guild of Australia is funding research to develop, implement and evaluate an educational program for community pharmacists in palliative cancer care. The major aims of the program are to increase the knowledge and skills of pharmacists in the delivery of effective palliative care, and as a result, improve the medication knowledge of palliative care patients. This may, in turn, reduce health costs such as hospitalisations due to medication errors. My name is Safeera Hussainy, and I will be doing this research as a PhD candidate under the supervision of: Prof Roger Nation, Dr Jennifer Marriott and Mr Michael Dooley who are from the Department of Pharmacy Practice, Victorian College of Pharmacy, Monash University.

Palliative care relates to the care of patients who have a progressive life-threatening illness. Approximately 70 to 80% of patients receiving palliative care are at home, and most receive ongoing prescription and over-the-counter medication from their community pharmacist. Many community pharmacists, however, may not have the knowledge, skills and confidence to contribute effectively to the delivery of palliative care services to people living in the community. If given adequate education and training, community pharmacists are in an ideal position to offer an increased range of services.

Why You Are Being Invited to Participate
Approximately 100 Australian pharmacists will be recruited to assist in determining the educational needs of pharmacists in the area of palliative cancer care. By completing a short questionnaire, you will assist in the design of an educational program for pharmacists to improve their ability to manage palliative care patients in the community.

We are seeking pharmacists from any part of Australia, to complete this questionnaire, which will take approximately 10 to 20 minutes of your time. Your participation is voluntary; return of the questionnaire will indicate your consent. Your personal information will be de-identified. That is, you will be identified by a code number so you remain anonymous.

You will not be paid for your participation in this project, but will be given the opportunity to participate in the educational program that is developed.

You may withdraw from the project at any time by informing the research project team.
Your anonymity
No findings which could identify you as an individual participant will be published. Only the combined results of participants will be published. You may contact the research project team if you would like a copy of the results. Only the researchers will have access to the original data, which will be retained in the department for five years after completion of the project. After this time, the data will be disposed of by shredding.

Questions
If you have any questions or would like to be informed of the research findings, please contact: Safeera Hussainy, Victorian College of Pharmacy, Monash University, Department of Pharmacy Practice, 9903 9057 (telephone) or 9903 9629 (fax).

Complaints
Should you have any complaint concerning the manner in which this research (project number: 2003/834MC) is conducted, please do not hesitate to contact the Research Ethics Committees below.

The Secretary
The Standing Committee on Ethics in Research Involving Humans
Building 3D
Research Grants & Ethics Branch
Monash University
Victoria 3800
Telephone +61 3 9905 2052
Fax +61 3 9905 1420
E-mail: scerh@adm.monash.edu.au

Vicky Karitinos
Secretary of the research Ethics Committee, mercy Health & Aged care
c/o mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone + 61 3 9270 2837
E-mail: vkaritinos@mercy.com.au

Thank you.

Safeera Hussainy,
(PhD Research Scholar)
(ph: 03 9903 9507)
APPENDIX G: Survey pharmacists – Registering interest to participate in the online educational program

MONASH University

IMPROVING MEDICATION MANAGEMENT OF PALLIATIVE CARE PATIENTS: ENHANCING THE ROLE OF COMMUNITY PHARMACISTS

If you have filled out the questionnaire and would like to participate in the educational program that is developed for community pharmacists in palliative cancer care, please write down your contact details below.

Name: ____________________________________________

Telephone: (___)__________________________________

Email: ____________________________________________

This information will be used only for contacting you and offering you the opportunity to participate in the educational program, otherwise your details will remain confidential.
**APPENDIX H: Pharmacists’ survey: Additional responses**

<table>
<thead>
<tr>
<th>Need for an accessible resource or program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good idea - cancer drugs are always evolving so it would be good to have an easy accessible resource to stay up to date, and therefore better help palliative care patients and their carers.</td>
</tr>
<tr>
<td>It would be very helpful to learn and understand more about the disease, the medications involved &amp; how better to assess these pts.</td>
</tr>
<tr>
<td>…we do not get enough opportunity to learn by actively observing prescription habits and interacting with these patients/carers/nurses.</td>
</tr>
<tr>
<td>…there are still many things I would like to learn and welcome your enquiry.</td>
</tr>
<tr>
<td>Good idea for us in the country to do in our own time. Important area where we need correct information.</td>
</tr>
<tr>
<td>With increased knowledge I could potentially give value added benefit to my customers. Education in this area would be valuable.</td>
</tr>
<tr>
<td>I would strongly support any online palliative care educational program. Information on cancer is often hard to obtain.</td>
</tr>
<tr>
<td>Your initiative in wishing to develop such an educational tool for community pharmacists is to be commended. I for one would welcome an opportunity to learn more about this area. Thank you.</td>
</tr>
<tr>
<td>A good overall view of patient management would be useful.</td>
</tr>
<tr>
<td>Our pharmacy's interactions with those needing palliative care and their families is challenging on many fronts and often very rewarding in a human sense. The better qualified we are for our support role the more positive an impact we can have.</td>
</tr>
<tr>
<td>My job is mainly administration. I would possibly have a general look at a site as part of keeping informed.</td>
</tr>
<tr>
<td>Definitely need to know more as many people are affected by cancer and we interact regularly with them or their carers.</td>
</tr>
<tr>
<td>I’d love more information on treatment of breakthrough pain with patients already on morphine.</td>
</tr>
<tr>
<td>Although we do not deal with hospitals and nursing homes it would be valuable to have a better understanding of the topic.</td>
</tr>
<tr>
<td>- Pain management at the general practitioner level is very poor and it is quite difficult to speak to general practitioners about ongoing pain management outside specialist care.</td>
</tr>
</tbody>
</table>
## APPENDIX H continued - Pharmacists’ survey: Additional responses

### Varying need for a community pharmacy palliative cancer care service

- … dispensing for palliative care patients is a relatively rare event.

- New to pharmacy in Australia. Not dealt with issues relating to palliative care in cancer patients in the past.

- Although my answer to question 10b is less than monthly, there are times when the pharmacy will do prescriptions for the supply of palliative care products more often.

- I have had limited experience via a palliative care hospice 10 years ago when the concept was first being available to the community. Since the hospice was forced to relocate, I have only intermittent experience through different customers as their needs have arisen. Unfortunately, I have not had any further formal training in the field. But as more patients are sent home rather than being treated in hospital I feel we as pharmacists are going to ‘be required’ to give greater support to the patient and their families or carers. So more training is going to be required for the pharmacist.

- I am on Palliative care access steering committee for Wide Bay Region in Queensland. Please don't link only cancer with palliative care. i.e. motor neurone disease, cystic fibrosis, multiple sclerosis.

### Community pharmacists as an easily accessible community resource for patients and families

- I think there is a big need for patients to have an accessible person with whom they can discuss their cancer treatment issues. Most patients I’ve spoken to, while they find their doctors supportive, need to have issues explained in a simple way.

- Pharmacists are increasingly required to provide health services to the community more and more patients are relying on free health advice and information that never before due to a health system not coping with demand.

### Community pharmacist’s role in provision of palliative cancer care

- My previous experience in patients needing palliative care has been filling of dose administration units (webster packs), delivery of medication and providing advice on their medicines.

- Commonly we deal with patients on strong pain relief medications for their cancer yet have little knowledge on the diagnosis and prognosis of these diseases, and their treatment with chemotherapy and radiotherapy.

- Our pharmacy's intentions with those needing palliative care and their families is challenging on many fronts and often very rewarding in a human sense. The better qualified we are for our support role the more positive an impact we can have.
APPENDIX H continued - Pharmacists' survey: Additional responses

**Program design issues**

**Face-to-face versus online**

- Please make the program in a few locations so we can get there faster and also [make the starting] time a bit later [so people can attend after work].

**Different knowledge levels**

- I think you need to cater for all levels of prior knowledge form zero to expert. This may mean some revision for some people – but that’s always valuable anyway. I have not ranked myself as excellent in any areas – nobody’s perfect! There’s always something to be learnt.

**Internet access**

- I don’t have online facility at work.
- No internet access.
- No access to internet at work or home.
- Not particularly comfortable using the internet and I would rather have an education module in booklet form that can be referred to easily.

**User-friendly, relevant, time efficient**

- …the information provided on such a site needs to be extremely user friendly and cover as much relevant information as possible into a relatively time efficient process.
- A good overall view of patient management would be useful. A guide of symptoms and options of treatment suggested in a table form.
- [Regarding multi-choice questions]: "won’t do them"; [regarding web-based moderated discussion group]: “maybe”.
- I’d love more information on treatment of breakthrough pain with patients already on morphine.

**Time constraints**

- Time/ Lack of time, and lower priority to me than other things.
- [Answered that they would participate in a program] depending on the time involvement.
- [Answered that they would not participate in the program because] time is the only limiting factor, otherwise I would love to.
- It is increasingly difficult for pharmacists to run their businesses and have the time to take in this information.
- Concerns of time constraints - otherwise would participate if suitable time.
- …might take a while to get it done!!
## Pharmacist’s recognition

### Remuneration

- At the risk of being cynical, unless there is appropriate payment "Enhancing the role of community pharmacists" doesn't pay the bills – Home Medicine Reviews are not a viable proposition as it is and our pharmacies (two of them) do not encourage the use. Further involvement in patient care without a fee is nonsensical. Unfortunately, Pharmaceutical Benefits Scheme remuneration is primarily based on the supply function with little or no financial recognition for the counselling and advice - until remuneration improves to reflect extra services, I can not justify our involvement - let other paid professionals do it.

### Professional development

- Pharmacist should be ‘accredited’ for this service. Once accredited they should be involved/included with palliative care hospital facilities to create referral systems etc to maintain interest and receive ongoing clients.

- Ensure it gets Pharmaceutical Society of Australia Continuing Professional Education points and it becomes more attractive.
APPENDIX I: Explanatory Statement for nominal group participants

Explanatory Statement: Key Stakeholders

Date:

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

About the Explanatory Statement
This Explanatory Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this Explanatory Statement carefully. Feel free to ask questions about any information in the document. Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information, and that you give your consent to participate in the research project. You will be able to keep a copy of the Explanatory Statement for your record.

The Aim of the Research Project
The Pharmacy Guild of Australia is funding research to develop, implement and evaluate an educational program for community pharmacists in palliative cancer care. The major aims of the program are to increase the knowledge and skills of pharmacists in the delivery of effective palliative care, and as a result, improve the medication knowledge of palliative care patients. This may, in turn, reduce health costs such as hospitalisations due to medication errors. My name is Safeera Hussainy, and I will be doing this research as a PhD candidate under the supervision of: Prof Roger Nation, Dr Jennifer Marriott and Mr Michael Dooley who are from the Department of Pharmacy Practice, Victorian College of Pharmacy, Monash University.

Palliative care relates to the care of patients who have a progressive life-threatening illness. Approximately 70 to 80% of patients receiving palliative care are at home, and most receive ongoing prescription and over-the-counter medication from their community pharmacist. Many community pharmacists, however, may not have the knowledge, skills and confidence to contribute effectively to the delivery of palliative care services to people living in the community. If given adequate education and training, community pharmacists are in an ideal position to offer an increased range of services.

Why You Are Being Invited to Participate
We are seeking the views of key stakeholders on the educational needs of community pharmacists/chemists in palliative cancer care. Key stakeholders include doctors, nurses, pharmacists, and, people requiring palliative care and their carers or family members.

Being part of this project involves participation in a focus group which will take approximately 2 hours. Views expressed by you will help in the design of the educational program for community pharmacists in palliative cancer care.

You will be paid a set fee for your participation in this project.

You may withdraw from the project at any time by informing the research project team.
Your anonymity
No findings which could identify you as an individual participant will be published. Only the combined results of participants will be published. You may contact the research project team if you would like a copy of the results. Only the researchers will have access to the original data, which will be retained in the department for five years after completion of the project. After this time, the data will be disposed of by shredding.

Questions
If you have any questions or would like to be informed of the research findings, please contact:
Safeera Hussainy, Victorian College of Pharmacy, Monash University, Department of Pharmacy Practice,
9903 9057 (telephone) or 9903 9629 (fax).

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Should you have any complaint concerning the manner in which this research (project number: 2003/834MC) is conducted, please do not hesitate to contact the Research Ethics Committees below.

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E-mail: scerh@adm.monash.edu.au

Vicky Karitinos
Secretary of the Research Ethics Committee, Mercy Health and Aged Care
C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: vkaritinos@mercy.com.au

Safeera Hussainy.
(PhD Research Scholar)
(99039007)

Thank you
APPENDIX J: Consent form for nominal group participants

Informed Consent Form for Key Stakeholders (doctors, nurses, and pharmacists)

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

I agree to take part in the above Monash University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I have for my records. I understand that agreeing to take part means that I am willing to:

- Participate in a focus group to determine the educational needs of community pharmacists in palliative cancer care.
- Allow the focus group session to be audi-taped.
- Provide demographic information about myself.

I understand that any information I provide is confidential, and that no information that could lead to my identification will be disclosed in any reports on the project, or to any other party.

I also understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Thank you.

__________________________ (Your signature)

__________________________ (Your printed name)

__________________________ (Date)
APPENDIX K: Development of the nominal group questions

A three-stage iterative process was used refine the nominal group questions asked of the participants:

i) Following a review of the literature (Section 4.1.1), seven questions were drafted (Figure 1a)

ii) Following a review of the results of the pharmacists’ survey (Section 4.1.2), and a review by the PRG, four new, more focussed questions were developed (Figure 1b)

iii) Following a review of research using nominal groups (Delbecq, Van de Ven, & Gustafon, 1975)) two questions were finally identified (Figure 1c) to address the objectives of conducting the nominal groups (Section 3.1.3.4.1).

<table>
<thead>
<tr>
<th>Stages in the development of the nominal group questions</th>
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<tbody>
<tr>
<td><strong>a) Questions developed from the literature</strong></td>
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<tr>
<td>1. What do you believe is the pharmacists’ role in the delivery of palliative care to the community?</td>
</tr>
<tr>
<td>2. Do you think that pharmacists are currently carrying out these roles and providing these services to the palliative care community?</td>
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<tr>
<td>3. What do pharmacists need to better provide palliative care services?</td>
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<tr>
<td>4. In what areas do pharmacists need education?</td>
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<tr>
<td>5. What skills do pharmacists need?</td>
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<tr>
<td>6. What areas are the most important?</td>
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<tr>
<td>7. How would a palliative care educational program for pharmacists benefit you?</td>
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</tbody>
</table>

| **b) Questions refined from a review of the results of the pharmacists’ survey and further review by the PRG** |
| 1. What do community pharmacists need to know about palliative care? |
| 2. Are the modules presented, appropriate? |
| 3. Are the topics presented, appropriate? |
| 4. What are the 3 - 5 key messages that need to be embedded in each module? |

It was expected that irrelevant material and gaps in material would be identified during the group meetings

| **c) Questions used for the nominal groups** |
| 1. Consider the draft of the educational program for community pharmacists that you have been given; what modules do you think need to be included in the program? |
| 2. What are the 3 key messages that need to be addressed in each of the modules? |

Figure 1: Stages in the development of the nominal group questions
APPENDIX L: Information given to nominal group participants in preparation for group meetings

Project Overview

Background

Palliative care relates to the care of patients who have a progressive life-threatening illness; most commonly cancer. Approximately 70 to 80% of patients receiving palliative care are at home, and most receive medications from their community pharmacist. Some community pharmacists, however, may not have the knowledge, skills and confidence to contribute effectively to the delivery of palliative care services to people living in the community.

If given adequate education and training, community pharmacists are in an ideal position to offer an increased range of services, including:
- the supply of prescription (eg. morphine) and over-the-counter medicines/products (eg. laxatives, saliva substitutes, wound dressings)
- the provision of evidence-based information related to palliative care medicines
- the education of patients/carers regarding the medication management of their condition (eg. drug interactions)
- the education of patients/carers regarding the use of delivery devices used to administer medicines (eg. infusion pumps).

Aim

To increase the knowledge and skills of pharmacists in the delivery of effective palliative cancer care, and as a result, improve the medication knowledge of palliative care patients.

Stages

Stage 1- Identification of the educational needs of community pharmacists.
- Comprehensive literature review.
- A questionnaire completed by pharmacists throughout Australia (see page.2 for results)
- Focus groups with key stakeholders (doctors, nurse and pharmacists).

Stage 2- Development and delivery of educational program.
- The results from Stage 1 will be used to inform the contents of the program.
- The program will be delivered to:
  - 30 pharmacists practising in western metropolitan Melbourne.
  - Pharmacists from the survey group who registered their interest in participating in the program.

Stage 3- Implementation trial and evaluation.
- Implementation trial to determine the impact of pharmacists’ interventions on patient care.
- Evaluation of the impact on patient care, pharmacist and patient knowledge and interaction with other palliative care health professionals.
Summary of Results from the Educational Pharmacists Questionnaire

Respondents
1050 questionnaires were posted to 500 pharmacies in urban and rural Australia.
108 questionnaires (10%) were returned by the closing date of 1 month after their postal.

Questions Asked
Demographic information.

Educational needs in palliative care by asking them to rate:
a) The importance to them of learning more about 18 palliative cancer care topics (Table 1, see pg3)
b) Their level of knowledge of the same topics.

Preference for format(s) that they would find valuable to use in the program. These were:
- Information as text
- Case studies
- Self-assessed multi-choice questions
- Moderated and Open discussion groups.

Willingness to participate in an online educational program.

Whether or not they deliver palliative care.

Any other comments.

Main results

Demographic information
55% of pharmacists were male and 45% were female. Most pharmacists (40%) were 40 to 49 years of age. The majority of pharmacies in which the pharmacists worked were urban (79%), compared with rural (21%) areas. The average number of years of practice as a registered pharmacist was 22.

Educational needs in palliative cancer care
a) The importance to them of learning more about the 18 palliative cancer care topics

On average, pharmacists rated all of the 18 topics as being important to learn more about:

- Very important to learn more about were:
  - Management of cancer pain
  - Management of non-pain symptoms/side effects
  - Drug interactions with palliative cancer treatments
- Least important to learn more about was:
  - Incidence and prevalence of cancer
b) Their level of knowledge of the same topics.
   • Pharmacists rated their knowledge of 10 of the topics as **poor to good**:
     ➢ Management of cancer pain
     ➢ Management of non-pain symptoms/side effects
     ➢ Drug interactions with palliative cancer treatments
     ➢ Common cancers: risk factors, presentation, treatments, prognosis
     ➢ Principles of palliative care
     ➢ Access to palliative cancer medications
     ➢ Palliative cancer treatments
     ➢ Communicating with patients and families
     ➢ Causes of cancer
     ➢ Incidence and prevalence of cancer
   • Pharmacists rated their knowledge of 8 of the topics as **very poor to poor**:
     ➢ Complementary and alternative medicines used by patients with cancer
     ➢ Terminology used in palliative care
     ➢ Long-term complications of chemotherapy
     ➢ Methods of drug administration in palliative cancer care
     ➢ Psychosocial care of patients
     ➢ Handling of cancer emergencies
     ➢ Conducting medicine reviews for patients
     ➢ Diagnosis and staging of cancer

**Preference for format(s)**
   • Pharmacists preferred information as text (90%), case studies (81%) and self-assessed multi-choice questions (69%) as formats they would find valuable to use in the educational program.
   • They least preferred open (12%) and moderated (27%) discussion groups.

**Willingness to participate in an online educational program**
   • The majority of pharmacists (86%) reported that they were willing to participate in the educational program.
   • Pharmacists who were not willing stated that they did not have the time to undertake the program or did not have access to the internet.

**Delivery of palliative care services**
   • The majority of pharmacists (71%) indicated that they do deliver palliative care services to patients in the community, and 25% indicated that they do not.
   • Most pharmacists delivered services less than monthly (24%) and weekly (21%), followed by monthly (13%), fortnightly (8%) and daily (6%).

**Other comments made by pharmacists**
These fell into 7 categories:
   • Need for an accessible resource or program
   • Varying need for a community pharmacy palliative care service
   • Pharmacists are an easily accessible community resource for patients and families- role of community pharmacists in palliative care
   • Program design-issues
   • Time constraints
   • Pharmacist’s recognition
   • Other issues eg palliative care encompasses more than cancer care
### Table 1: 18 Palliative cancer care topics that pharmacists were asked to rate

<table>
<thead>
<tr>
<th>Topic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Principles of Palliative Cancer Care</td>
<td></td>
</tr>
<tr>
<td>Causes of Cancer</td>
<td></td>
</tr>
<tr>
<td>Incidence and Prevalence of Cancer</td>
<td></td>
</tr>
<tr>
<td>Diagnosis and Staging of Cancer</td>
<td></td>
</tr>
<tr>
<td>Common Cancers: Risk Factors, Presentation, Treatments, Prognosis</td>
<td></td>
</tr>
<tr>
<td>Management of Cancer Pain</td>
<td></td>
</tr>
<tr>
<td>Management of Non-pain Symptoms/Side Effects</td>
<td></td>
</tr>
<tr>
<td>Palliative Cancer Treatments</td>
<td></td>
</tr>
<tr>
<td>Long-Term Complications of Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Handling of Cancer Emergencies</td>
<td></td>
</tr>
<tr>
<td>Drug Interactions with Palliative Cancer Treatments</td>
<td></td>
</tr>
<tr>
<td>Complementary and Alternative Medicines used by patients with cancer</td>
<td></td>
</tr>
<tr>
<td>Methods of Drug Administration in Palliative Cancer Care</td>
<td></td>
</tr>
<tr>
<td>Access to Palliative Cancer Medications</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Care of patients</td>
<td></td>
</tr>
<tr>
<td>Communicating with patients and families</td>
<td></td>
</tr>
<tr>
<td>Terminology Used in Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Conducting Medicine Reviews for patients (at home, in residential aged care facilities and hospices)</td>
<td></td>
</tr>
</tbody>
</table>
MODULE CONTENTS FOR REVIEW BY FOCUS GROUPS

PALLIATIVE CANCER CARE PROGRAM FOR COMMUNITY PHARMACISTS

Aim of the Educational Program

To increase the knowledge and skills of pharmacists in the delivery of effective palliative cancer care, and as a result improve the medication knowledge of palliative care patients.

The educational program will be 20-hours, to be completed over 3 months – at a rate of approx. 2 hours per week or so, which will vary between pharmacists. The program will be presented on-line.

Draft of Module Topics

1. Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence (1 hour)
2. Management of cancer pain (4 hours)
3. Management on non-pain symptoms/side effects (4 hours)
4. Complementary and alternative medicines and therapies used by patients with cancer (1 hour)
5. Access to palliative cancer care medicines and methods of drug administration in cancer treatments (1 hour)
6. Psychosocial care and communication with patients and families (1 hour)
7. Working in partnership and conducting medication management reviews to enhance patient care (1 hour)
8. Using critical reflection to enhance patient care (1 hour)

Preliminary discussions suggest that drug interactions with palliative cancer treatments will be discussed in modules 2, 3, and 4.
Overview of the Modules
A present, there are eight separate modules focussing on both clinical and service aspects of the delivery of medication management to palliative care patients. The aim of these modules is two-fold. Firstly, to provide community pharmacists with an opportunity to explore what is clinically relevant to them. Secondly, it is important to have this information available, and in a format that is readily accessible to them when they are ready to use it. Modules can be undertaken in any order and over a period of time suitable to the pharmacist and their other commitments. It is important to acknowledge that this is not only a ‘program’ but a valuable resource.

Draft Module Structure
There will be a common structure for each of the modules.

Key messages
The important points that community pharmacists need to know.

Utilisation of case studies
Clinical case studies throughout the program need to have hyperlinks to incidence & prevalence of the cancer being discussed, its causes, diagnosis, stages & cancer treatments. This may be in table format.

The common cancers, their signs & symptoms, natural history, prognosis and management will also be embedded into the various case studies, & hyperlinked to relevant information.

Four to five case studies, covering the common cancers may be developed that filter throughout the program.

Areas such as access to medicines, psychosocial issues, working in partnership and critical analysis can be embedded into comprehensive case studies and hyperlinked to relevant modules. However, writers need to be careful that participants don’t get frustrated by being forced to use hyperlinks too often.

Sub-sections
[interspersed with]:
• hyperlinks to evidence-based web site resources
• critical analyses/reflective exercises
• collaborative exercises/postings to notice board etc
• self-test multiple-choice questions
• references

Addressing divergent views (where applicable)

Addressing adherence issues (where applicable)

Highlighting practice points
Suggestions of practical relevance related to the area

Key summary points
**APPENDIX M: Results of the independent voting stage of the nominal group process:** Example of one pharmacist’s choice of the eight most important modules

<table>
<thead>
<tr>
<th>Number allocated to module on the flip chart</th>
<th>Module</th>
<th>Importance rank by participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Introduction and principles of palliative care</td>
<td>8</td>
</tr>
<tr>
<td>22</td>
<td>Working in partnership and medication management reviews</td>
<td>7</td>
</tr>
<tr>
<td>17</td>
<td>Management of cancer pain</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Most common cancer drugs used and anything else coming up/side effects of medicines and disease states they impinge on</td>
<td>5</td>
</tr>
<tr>
<td>23</td>
<td>Using critical reflection to enhance patient care</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>Psychosocial care and communication with patients and families</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>Where to go for help – resources</td>
<td>2</td>
</tr>
<tr>
<td>20</td>
<td>Access to palliative care medicines and methods of drug administration</td>
<td>1</td>
</tr>
</tbody>
</table>
APPENDIX N: Results of the nominal group process that were sent to the participants for validation

NGT Focus Groups: Pharmacists

*Wednesday 4th August 2004 - Held at VCP*

Numbers present: 7

Both lists below were used at the ranking stage of the process

*Additional Groups Ideas*

- Working with other health providers to deliver integrated care; regular communication and role identification (to go into Working in partnerships …)
- Most common cancer drugs used and anything else coming up in the next 6 months – to include chemotherapy, radiotherapy, immunotherapy etc – to include side effects of the medicines and other disease states as they impinge on daily living (to go with Access to medicines and methods of drug administration)
- Crushing/altering dosage forms — regular consistent outcomes, administration via PEG tube (to go with Access to medicines & methods of drug administration)
- Care of the carer and palliative care worker/team, include professionals as well.
- Associated pathologies eg cardiac and other comorbidities
- Pain pathways
- Differences between different analgesics
- Dietary supplements and alternatives (to go with Complementary and alternative medicines and therapies)
- Possible prognosis and acceptance of prognosis (to go with Psych-social care and communication)
- Where to go for help – resources and future resources for professionals and patients/carers, liaison with other health professionals, back-up, websites – searching techniques, different State and Territory legislation
- Counselling guidelines for patients (to go with Psych-social care and communication)
- Care of the family member after bereavement (to go with Psych-social care and communication)
- Issues re provision of medicines — PBS, SAS, S100 (to go with Access to medicines and methods of administration)
- Providing written and verbal information to patients and carers (to go with Psych-social care and communication)
**Ideas from PRG, Lit Review & Survey**

Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence  
Management of cancer pain  
Management of non-pain symptoms/side effects  
Complementary and alternative medicines and therapies used by patients with cancer  
Access to palliative cancer care medicines and methods of drug administration in cancer treatments  
Psychosocial care and communication with patients and families  
Working in partnership and conducting medication management reviews to enhance patient care  
Using critical reflection to enhance patient care

**Group Priorities**

<table>
<thead>
<tr>
<th>Introduction to principles of palliative care ) (ceiling doses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of cancer pain (ceiling doses)</td>
</tr>
<tr>
<td>Management of non-pain symptoms and side effects</td>
</tr>
<tr>
<td>Complementary and alternative medicines, therapies, and dietary supplements</td>
</tr>
<tr>
<td>Access to palliative care medicines and methods of administration ceiling doses, cost issues, pharmacist awareness of continuity of supply, [from participant additional items above - Most common cancer drugs used and anything else coming up in the next 6 months, Crushing/altering dosage forms – regular consistent outcomes, administration via PEG tube])</td>
</tr>
<tr>
<td>Psycho-social care and communication with patients and families (from participant additional items above - Counselling guidelines for patients, providing written and verbal information to patients and carers)</td>
</tr>
<tr>
<td>Working in partnership and medication management reviews (from participant additional items above - Working with other health providers to deliver integrated care, ongoing, regular communication and role identification)</td>
</tr>
<tr>
<td>Using critical reflection to enhance patient care (What does this mean? - Clarified)</td>
</tr>
<tr>
<td>Most common cancer drugs used and anything else coming up / side effects of medicines and disease states they impinge on</td>
</tr>
<tr>
<td>Care of the carer and palliative care worker/team</td>
</tr>
<tr>
<td>Associated pathologies</td>
</tr>
<tr>
<td>Where to go for help – resources now and in the future</td>
</tr>
</tbody>
</table>

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Appendix N
### Ranking of group priorities

<table>
<thead>
<tr>
<th>Modules</th>
<th>Ranking 1= least important 8= most important</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and principles of palliative care</td>
<td>7-8-8-8-8-8-8-8</td>
<td>55</td>
</tr>
<tr>
<td>Management of cancer pain</td>
<td>7-7-6-7-7-7-7-4</td>
<td>45</td>
</tr>
<tr>
<td>Working in partnership and medication management reviews</td>
<td>5-5-5-4-7-5</td>
<td>31</td>
</tr>
<tr>
<td>Psycho-social care and communication</td>
<td>6-4-3-5-6-6</td>
<td>30</td>
</tr>
<tr>
<td>Management of non-pain symptoms and side effects</td>
<td>3-6-6-3-4</td>
<td>22</td>
</tr>
<tr>
<td>Where to go for help – resources</td>
<td>3-2-2-2-1-2-8</td>
<td>20</td>
</tr>
<tr>
<td>Access to palliative care medicines and methods of administration</td>
<td>2-2-3-3-1-2-4</td>
<td>17</td>
</tr>
<tr>
<td>Complementary &amp; alternative meds/treatment: the group prioritised this instead of Crit Reflect as in the top 8 *</td>
<td>1-1-4-1-1-1-1</td>
<td>8</td>
</tr>
<tr>
<td>Using critical reflection to enhance patient care (What does this mean? - Clarified)</td>
<td>6-4</td>
<td>10</td>
</tr>
<tr>
<td>Most common cancer drugs used and anything else coming up / side effects of medicines and disease states they impinge on</td>
<td>2-1-5</td>
<td>8</td>
</tr>
<tr>
<td>Care of the carer and palliative care worker/team</td>
<td>5-3</td>
<td>8</td>
</tr>
<tr>
<td>Associated pathologies</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

There is one extra 1 & 2 recorded

[Participants did not want to ‘let go’ of some areas and kept collapsing two together in ranking phase – asked that they make decisions to guide the educational program development]
Eight most important modules [top 8 scores]

Introduction and principles of palliative care
Management of cancer pain
Working in partnership and medication management reviews
Psychosocial care and communication
Management of non-pain symptoms and side effects
Where to go for help
Access to palliative care medicines and methods of administration
Complementary and alternative medicines/treatments

Identifying Key Messages in various Modules

Introduction and principle of palliative care

- What is palliative care? What does it mean for patient and family?
- Palliative care is different to any other disease state and there are a lot of people involved
- Aim is not to cure
- Prognosis and duration
- Scope of palliative care
- Best outcome short term
- Who’s in the team
- Types of patients, age of patients
- Ceiling doses [considered very important by participants]
- Disease progression: poor → unwell → dead and opportunities to treat patient along the journey to make them comfortable
Management of cancer pain

- Aim for patient comfort
- Treatments used and alternatives
- Explanation of pain pathways and analgesic use
- Adjuvants
- Opiate dose conversion
- Determine pain threshold indirectly or directly
- Importance of regular dosing not prn dosing
- Dose just sufficient to decrease pain
- Constipation
- Emergency top-up treatment – when and where – escalating treatment
- Pain must go away
- Dosage form alteration
- Drug access

Working in partnership and conducting medication management reviews

Ensure patient provided with knowledge of partnerships

- Liaison between palliative care workers
- Knowing your hospital pharmacists
- Awareness of patient/family dynamics
- List of all health providers associated with every patient – contact numbers eg specialists, family members
- Care of the palliative care team
- Overcoming barriers of privacy legislation
- Regular MMRs
- Acknowledgement of each others strengths, weaknesses and roles in the palliative care team
- Who knows what?
- Managing side effects of drug treatment
- MMRs for palliative care patients aren’t outside the norm

Psycho-social care and communication with patients and families

- Awareness of not only physical aspects – spiritual and psycho-social – holistic
- Counselling tools
- Moving into and out of care and respite for carers
- Ask patient/carer/family if GP has explained everything – clarification
- It’s OK to go through a range of emotions – anger, sad
- What each medicine is used for – explain (detail) to patient/carer
- What is grief and bereavement (not necessarily at the time of death)
- Carer support
- Organisations who can assist with psycho-social aspects – a list eg church, social workers
- Prognosis and acceptance
- Care of family members after bereavement
- Who to talk to and privacy issues associated with it
- Who you can go to for help in the team
- What patients/family want and need to know - what to tell them

**Management of non-pain symptoms and side effects**
- Mouth care – products
- Constipation, bowel obstruction
- Nausea and vomiting
- Breathing, O₂
- Depression
- Mobility
- Fatigue
- Delirium
- Emergencies – what constitutes one?
- Cachexia
- Swallowing difficulties
- Wound care: Pressure ulcers

[were running out of time here – had little time to think about these key messages]
Complementary and alternative medicines and therapies and dietary supplements

- Dietary supplements especially for constipation
- How long to treat with CAM without changing outcome
- What do patients use – folk law, coffee enemas, juicing – how it impacts on pharmacists role
- Interactions with conventional medicines
- Role of enteral nutrition, interactions
- Anti-oxidants and vitamins
- Impact of dehydration
- Palliative care at end-of-life – when is it appropriate to withdraw dietary supplements and patient/family have opportunity to voice that – to refuse medicines (?) intro intro - Duty of care issues
- Current evidence in the literature - home/diet/nutrition
- Different types of supplements
- Other modalities – massage, aromatherapy, music therapy
- Use of CAM may be a lost opportunity to treat
- Alright not to eat today

Overall messages
As time was short - Participants were asked to each state: “If they had one key message that they wanted to get across what would it be?”

Holistic care of patient including family after patient dies
Strong knowledge of analgesics
Remove pain and make patient and family feel comfortable
Moving market therefore needs communication
What is palliative care? Aim?
Treating more than one person
Document for Participant Validation
NGT Focus Groups: Doctors
Tuesday 3rd August 2004 - Held at VCP

Numbers present: 6

Both lists below were used at the ranking stage of the process

Additional Groups Ideas
Ethical issues
Navigating palliative care options in cancer care
Non-malignant cancer care (to go onto intro)
Research issues (to go into intro)
Familiarisation of well-utilised resources (both pharmacist and pt need to know these as pt often comes in having looked at these) collapsed with Palliative care treatments – chemo, radiotherapy, immunotherapy, hormonal, analgesia
Psycho-oncology – to include anxiety, depression, delirium (collapsed into psychosocial care and communication)
Drug interactions and side effects (contextualise)
Alternative routes for drug administration (collapsed into access to medicines and methods of drug administration)
HIV/AIDS – (to go into intro)
Off-license use of medicines – collapsed with access to palliative care medicines in the community – SAS, sympathetic costing, ethics of non-PBS medicines, new PBS listing
Increased prevalence of cognitive impairment and relation to drug compliance (psycho-social care, medication reviews)
Nutrition
**Ideas from PRG, Lit Review & Survey**

Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence
Management of cancer pain
Management of non-pain symptoms/side effects
Complementary and alternative medicines and therapies used by patients with cancer
Access to palliative cancer care medicines and methods of drug administration in cancer treatments
Psychosocial care (vs psycho-oncology) and communication with patients and families
Working in partnership and conducting medication management reviews to enhance patient care
Using critical reflection to enhance patient care
### Appendix N

**Group Priorities**

<table>
<thead>
<tr>
<th>Ethical issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigating palliative care options in cancer care (from participant additional items above - Familiarisation of well-utilised resources (both pharmacist and pt need to know these as pt often comes in having looked at these) collapsed with Palliative care treatments – chemotherapy, radiotherapy, immunotherapy, hormonal, analgesia)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Familiarisation of well-utilised resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug interactions and side effects (need to contextualise)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Introduction and principles of palliative care - (clinical diagnosis vs symptom diagnosis) (from participant additional items above – non-malignant cancer care, research issues, HIV/AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of cancer pain</td>
</tr>
<tr>
<td>Management of non-pain symptoms and side effects</td>
</tr>
<tr>
<td>Complementary and alternative medicines/treatment</td>
</tr>
<tr>
<td>Access to palliative care medicines and methods of administration (from participant additional items above – off-license use of medicines – SAS, sympathetic costing, ethics of non-PBS medicines, new PBS listing)</td>
</tr>
<tr>
<td>Psycho-social care (vs psycho-oncology) and communication (stigma, non-English speaking patients; cultural issues) (from participant additional items above – psycho-oncology to include anxiety, depression, delirium, increased prevalence of cognitive impairment &amp; relation to drug compliance)</td>
</tr>
<tr>
<td>Working in partnership and medication management reviews (multi-disciplinary teams)</td>
</tr>
<tr>
<td>Using critical reflection (What does this mean? - Clarified)</td>
</tr>
<tr>
<td>Nutrition</td>
</tr>
</tbody>
</table>
### Ranking of group priorities

<table>
<thead>
<tr>
<th>Modules</th>
<th>Ranking 1= most important</th>
<th>Converted Ranking 1= least important</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and principles of palliative care</td>
<td>3-1-3-1-1-1</td>
<td>6-8-6-8-8-8</td>
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<tr>
<td>Management of cancer pain</td>
<td>1-2-1-6-2-2</td>
<td>8-7-8-3-7-7</td>
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<tr>
<td>Management of non-pain symptoms and side effects</td>
<td>3-6-7-2-3-2</td>
<td>6-3-2-7-6-7</td>
<td>31</td>
</tr>
<tr>
<td>Access to palliative care medicines and methods of administration</td>
<td>5-5-4-4-6-5</td>
<td>4-4-5-5-3-4</td>
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<tr>
<td>Psycho-social care and communication</td>
<td>6-4-6-2-4</td>
<td>3-5-3-7-5</td>
<td>23</td>
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<tr>
<td>Ethical issues</td>
<td>3-5-5-4</td>
<td>6-4-4-5</td>
<td>19</td>
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<tr>
<td>Drug interactions and side effects</td>
<td>3-7</td>
<td>6-2</td>
<td>8</td>
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<tr>
<td>Navigating palliative care options in cancer care</td>
<td>6-7-7</td>
<td>3-2-2</td>
<td>7</td>
</tr>
<tr>
<td>Working in partnership and medication management reviews</td>
<td>5-8-8</td>
<td>4-1-1</td>
<td>6</td>
</tr>
<tr>
<td>Nutrition</td>
<td>8-8-8</td>
<td>1-1-1</td>
<td>3</td>
</tr>
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<td>Familiarisation of well-utilised resources</td>
<td>7</td>
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<td>2</td>
</tr>
<tr>
<td>Complementary and alternative medicines/treatment</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Using critical reflection (Clarified)</td>
<td>Agreement to underpin program</td>
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<td></td>
</tr>
</tbody>
</table>

Missing original numbers before conversion: one 4, 7 & 8 not stated or not recorded

During this meeting, ranking was based on feedback from the pilot participants which was 1 = most important and 8 = less important – adding the lowest scores being considered the priority areas. However, this did not accurately reflect what the participant’s priorities were. During the meeting we therefore added the scores of each module together, then ÷ by the number of participants who scored each item, then % - to get the lowest percentages – which became the priorities.
Since the meeting, the raw scores were converted to 1 = least important and 8 = most important. These were added, then the mean value of the independent judgements were calculated, and considered reflective of the group’s decision. This will be sent to participants to verify.

See below for priority order.
Eight most important modules [using the mean value of independent judgements as the group’s decision]

Introduction and principles of palliative care
Management of cancer pain
Management of non-pain symptoms and side effects
Ethical issues
Psychosocial care and communication
Access to palliative care medicines and methods of administration
Drug interactions and side effects
Navigating palliative care options in cancer care

Identifying Key Messages in various Modules

Management of cancer pain

- Mechanistic approach to pain and multi-modal treatment
- Complex pain management alternatives eg methadone, ketamine
- Recognition of poorly managed pain and associated issues of assessment and reasons
- Different types of pain
- Neurophysiology
- Classes of analgesics
- Adjuvant use
- Principle of cancer pain management – prn
- Possibility of good analgesia being achieved (good), dispel myths
- Opioids and toxicity
- Drugs available / approaches to pain management
Management of non-pain symptoms and side effects

- Prevalence and impact of these
- Dyspnoea and opiates
- Generalised effects of cancer – weight loss, cachexia, deconditioning
- 5 most common symptoms: eg dyspnoea, depression, delirium, nausea and vomiting, constipation, fatigue
- Skin and pressure care
- Sleep problems
- Specifics of constipation in palliative care
- Diagnostic approach to non-malignant symptoms
- Steroids
- [Multiple health problems eg they may be experiencing more than cancer]

Introduction and principle of palliative care

- HIV/AIDS
- Research issues
- Non-malignant cancer care
- “Small things do make a big difference” – response to patients/carers, attitudes
- Holistic
- Excellent symptom control not cure
- Palliative care is not equal to Terminal care
- Not all palliative care is done by specialists
- Brings up own feelings of vulnerability, anxiety – have to deal with these, not add to patient’s/family’s
- Knowledge of psycho-social supports available eg community hospice service
- Concept of total pain/suffering (Saunders, c. (Adrian)
- Quality of life issues – goal of care and should inform all decision making
- Knowledge of community supports

Ethical issues

- Introduction to principles of human healthcare ethics
- Sedation and end-of-life and relationships to euthanasia and physician-assisted suicide
- Understanding double effect/causality
- Compassionate costing – treatment/products and recommendation of products
- Decision making around NFR / treatment holding/discontinuing
Appendix N

- Evidence based practice
- Total symptom control at any cost – social, financial etc
- Being comfortable when dealing with pharmacological uncertainty
- State/territory laws differ
- Approaches to suspected misconduct by a team member/patient/family
- Stigma associated with heavy opioid use
- Cultural, social and religious issues – when patient doesn’t want to know
- Importance of out-of-hours access

Psycho-social care and communication
- Effective empathic communication skills
- Broad social impact – family, finances, sexuality, religion
- Recognition and knowledge of depression/anxiety. delirium
- Recognition of patients at risk of suicide and risk factors for complicated grief
- Spiritual distress in secular community
- Cultural issues – impact on family, decision making [both ways ie cultural issues of pharmacists/health professional as well as cultural issues of patient/family]
- Appropriate diagnosis and use of appropriate medicines eg in depression/anxiety
- Forming a treatment team and importance of communication – ensure approaches are similar among health professional team as well as with patient and family as part of the team
- Time required for care
- Communication with a patient who doesn’t know the diagnosis

Navigating options in cancer care
- Don’t be afraid to ask a 2nd or 3rd opinion/ further opinion
- Treatment: chemotherapy, hormonal etc eg bone metastases - types of palliation
- Evolving medicines use in aged care facilities and practical issues eg frequent changing of blister packs etc
- Support services available – disease-related and palliative care combined
- Who to refer to

Overall messages
As time was short - Participants were asked to each state: “If they had one key message that they wanted to get across what would it be?”
- Awareness and knowledge of 5 opiates used
- Pharmacist can make a difference as part of a loosely coordinated multi-disciplinary team
- Pharmacist input is welcome, don’t be afraid to lift the phone [better to ask and clarify etc]
- Small things can make a big difference – fine tuning re medication management
- Understanding from patients’ perspective – who’s interests are we serving?
- Palliative care is complex and messy, but gratifying if put time into it
- Non-pain symptoms can be distressing
- Communication with locum pharmacists – continuity of care between pharmacists
- Increasing number of persons will be requiring palliative care – explosion of palliative care services
- There’s always something you can do
NGT Focus Groups: Nurses – Frankston Area Palliative Care
Tuesday 10th August 2004 - Held at Frankston RDNS -Frankston
Numbers present: 5

Both lists below were used at the ranking stage of the process

**Additional Groups Ideas**

- Use of adjuvant treatment in pain control [to go into management of cancer pain]
- Use of palliative care medications in non-cancer patients [to go into introduction and principles of palliative care and management of cancer pain]
- Role of palliative care nurse in community setting – sees client on an ongoing basis (important role between pharmacist and nurse)
- Different types of pain we deal with in community [to go into management of cancer pain]
- Wound management: fungating wounds (other non-cancer conditions eg diabetes that the client has)
- Client/carer education re medications [to go into management of cancer pain, access to palliative care medications and methods of drug administration, psychosocial care and communication with patients/families, working in partnerships and conducting MMRs]
- Resources for clients/carers and pharmacists [to go into psychosocial care and communication with patients/families, working in partnerships and conducting MMRs]
- Understanding the ‘dying’ process—other symptoms—condition fluctuating [to go into psychosocial care and communication with patients/families]
- Chemotherapy and radiotherapy side effects
- Non-conventional medications used in palliative care eg beta blockers and anaesthetics in pain management [to go into management of cancer pain, management of non-pain symptoms and side effects]
- Nausea, bowels, respiratory function: non-pain symptom management [to go into management of non-pain symptoms and side effects]
Ideas from PRG, Lit Review & Survey
Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence
Management of cancer pain
Management of non-pain symptoms/side effects
Complementary and alternative medicines and therapies used by patients with cancer
Access to palliative cancer care medicines and methods of drug administration in cancer treatments
Psychosocial care and communication with patients and families
Working in partnership and conducting medication management reviews to enhance patient care
Using critical reflection to enhance patient care

Group Priorities
- Role of palliative care nurse in the community setting
- Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence
- Management of cancer pain
- Management of non-pain symptoms/side effects
- Complementary and alternative medicines and therapies used by patients with cancer (drug interactions)
- Access to palliative cancer care medicines and methods of drug administration in cancer treatments
- Psychosocial care and communication with patients and families
- Wound management
- Working in partnership and conducting medication management reviews to enhance patient care
- Using critical reflection to enhance patient care
- Chemotherapy and radiotherapy treatments and side effects
### Ranking of group priorities

<table>
<thead>
<tr>
<th>Modules</th>
<th>Converted Ranking</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and principles of palliative care</td>
<td>8-8-8-8</td>
<td>40</td>
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<tr>
<td>Management of cancer pain</td>
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<tr>
<td>Management of non-pain symptoms and side effects</td>
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<td>Psycho-social care and communication</td>
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<tr>
<td>Access to palliative care medicines and methods of administration</td>
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<td>Chemotherapy and radiotherapy side effects</td>
<td>5-5-3</td>
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<td>Complementary and alternative medicines/treatments</td>
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<td>Wound management</td>
<td>3-2</td>
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<tr>
<td>Working in partnership and medication management reviews</td>
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<tr>
<td>Using critical reflection</td>
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</tbody>
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### Eight most important modules [based on top 8 scores]

- Introduction and principles of palliative care
- Management of cancer pain
- Management of non-pain symptoms and side effects
- Role of palliative care nurse in the community setting
- Psycho-social care and communication
- Access to palliative care medicines and methods of administration
- Chemotherapy and radiotherapy side effects
- Complementary and alternative medicines/treatments
Identifying Key Messages in various Modules

Introduction and principle of palliative care
- Good symptom management - palliative care is palliative not curative, managing symptoms
- Availability and accessibility – open to anybody
- Most common types of cancer
- Life-threatening disease, not only cancer
- What palliative care is
- Client is main focus: listen to client/carer
- Broad definition of palliative care – not just final stage – could be couple of years after curative stage – not just terminal eg COPD
- Quality of life not quantity – good symptom management = quality of life
- Physical and psychological comfort aspects [to go into psychosocial care and communication with patients and families]
- Holistic care – ‘whole’ key! - not just 1 discipline – whole team – patient has various key players at different times of the disease process

Management of cancer pain
- Pain is what the client says is it
- There are various types of pain – tissue, neuropathic, psychological, physical, emotional etc
- Need to treat side effects as well as treating pain eg opioids, nausea and vomiting, constipation and appropriate medications to treat these
- Morphine phobias – cultural, educational – doctors who don’t know about palliative care and doses used; beginning of the end; drug of choice because has no ceiling
- Who cares about addiction? – doctors afraid to order morphine etc; nurses afraid of addiction if not educated in palliative care – without maxalon can leave patients with bad experiences: need education
- Need to use adjuvant medications with pain medications – Tegretol, dexamethasone, panadol, voltaren etc – are OK to use
- Critical review of pain control – monitor, who is monitoring?
- Good access to available medications – prescription not filled at pharmacy, especially on weekends especially if have pain; pharmacists: where can they get it quickly from elsewhere? Some pharmacists can get it from places and some can’t eg Dilaudid
- Chemotherapy and radiotherapy treatments in pain management – role of
- Linked closely with quality of life
Management of non-pain symptoms and side effects (of treatments)

- Common symptoms, management and medication management:
  - Nausea and vomiting
  - Bowel management
  - Respiratory function
  - Terminal restlessness
  - Anxiety and depression
- Need to act quickly to prevent serious outcomes eg hospitalisation
- Importance of monitoring and reviewing client
- Emotional pain and refer to counsellor
- Minimise distress to carers by appropriate and timely treatment of symptoms
- Being aware and having knowledge of other medical conditions eg diabetes
- Fatigue – no medication for

Role of the palliative care nurse in the community setting

- Coordinating care in community between local medical officers, physios, OTs, oncologists etc – not case managers
- Symptom management: that’s what nurses do
- Who, what, when of palliative care nursing – pharmacist should be aware – of how to access local palliative care nurses
- Palliative care district nurses are a valuable resource
- Palliative care nurses have most contact with client for monitoring and management
- Liaison person/member supporting family in community
- Link between patients and pharmacy
- Advocate for patient
- Provide hands-on nursing care – varies form service to service eg consultancy services – hours of service – on-call
- The pharmacist is a valuable resource for knowledge of medications, methods/routes of drug administration that the nurse can tap into
- Have a good relationship with community nurse
- Educating families to be independent with some of their care – diabetes: blood sugars; injections; personal care/hygiene; tending wounds; morphine: administering
- How to access community nurses – referral process
Psycho-social care and communication

- Language, cultural background and beliefs – need to be in pain: part of some cultures, still living if in pain; interpreter; ability to read label on medications; some cultures will only listen to information form a male; understand that some of the cultures have different beliefs about medications
- Access to counselling for patients/family if needed
- If communication isn’t clear in easily understood language eg can lead to treatment failure
- Taking time to listen
- Monitor coping at home (families) and refer as necessary
- Knowing who is involved in client’s care: other health professionals, not doubling up
- Availability of support services
- Being aware of community resources and how to access them – refer
- Important to keep treatment regimens in context of clients/carers and their individual situation: one solution doesn’t fit all
- Involvement of schools and churches – volunteer organisations
- Holistic care
- Who’s the decision maker: (in the) family – culture

NB – participants felt that role of PC nurses and psychosocial care and communication could be put together – no time left to discuss in further detail

Access to palliative care medications and methods of drug administration

- Availability of medications is especially important out of hours
- Knowing how to apply for non-PBS medications – bulk supplies
- Being aware of client’s palliative care state so pharmacists can get medications they may need
- Ongoing liaison with pharmacy: supplies of medications
- Planning for anticipated needs eg get medications in home before they’re needed
- Drug routes available in the community – will nurses give IV or not? Syringe drivers available in the community
- Knowledge of drugs and methods of administration: high doses used
- Costs to clients – not only paying for medications - being aware – expensive medications – especially if changing medications
- Disposal of unused medications – given to nurses often
Chemotherapy and radiotherapy side effects

- Being aware that client is having some form of these treatments
- Monitoring side effects and liaising with doctors as necessary
- Side effects can vary: moderate/severe/life threatening
- Education of clients/carers on what to expect re treatment
- Be aware of common chemo drugs used and side effects
- Skin condition post treatment
- Being aware of common problems patients may come in with
- Knowledge of preventing common problems, and if can’t prevent, what are their treatments
- Being aware of who are local oncologists and where local chemo treatment centres are
- Country areas: who would they tap into?

Complementary and alternative therapies and medicines used by patients with cancer

- What is the difference between ‘complementary’ and ‘alternative treatments, where do they fit in? – allied health etc
- Non-prejudice as they could be a threat to pharmacists – explore; non-judgemental; not disempowering the client: it’s their choice and responsibility
- Various treatments available: complementary and conventional – look at cost
- Need to be aware of interventions between prescribed medications and CAM treatments
- Simple treatments the pharmacist can recommend eg massage, aromatherapy, music therapy, reiki, hand and foot massage
- Being able to communicate with client that they are taking CAMs
- Making sure doctors and oncologist aware that patients are having eg massage – possibility of spread
- Alternative treatments being offered in the local area
- Legal professional responsibilities – where do you draw the line? Knowing your practices/protocols
- Coffee enemas

Overall messages

Participants were asked to each state: “If they had one key message that they wanted to get across what would it be?”

- Treat people how you want to be treated yourself
- Listen
- Trust and believe what people say
- Good understanding of palliative care and what’s involved
- Empathy
NGT Focus Groups: Nurses – Eastern Palliative Care

Thursday 5th August 2004 - Held at Eastern Palliative Care Services - Nunawading

Numbers present: 7

Both lists below were used at the ranking stage of the process

Additional Groups Ideas

- Syringe drivers, drug interactions, amount of drugs needed (stability of drugs – especially if left by family members – pharmaceutical guidelines versus palliative care for example for one month.) [to go into management of cancer pain, management of non-pain symptoms/side effects, access to palliative care medicines and methods of drug administration]
- Information guidelines for patients similar to those provided by hospital pharmacies re medicines [to go into psychosocial care and communication with patients and families]
- Nausea and vomiting
- Side effects of medications (eg coloxyl & senna “don’t take for two long because if its side effects” – sensitivity to its use in palliative care / pharmacists need to take care with wording) [to go into introduction to palliative care, psychosocial care and communication with patients and families]
- Most common types of supportive medicines patients would have at home (eg morphine, maxalon, diazepam – (wrong dose)) [to go into access to palliative care medications and methods of drug administration]
- Chemotherapy and radiotherapy treatments (longer duration drug needs and drug interactions) [management of cancer pain, management of non-pain symptoms and side effects]
- Polypharmacy in palliative care clients – (rationalisation of medications eg dexamethasone but not on zantac/losec or on different benzdiazepines) [to go into working in partnership and conducting MMRs]
- Drugs not available in the community (eg ketamine, cyclizine, hydromorphone??) [to go into access to palliative care medications and methods of drug administration, working in partnership and conducting MMRs]
- What community palliative care services provide: pharmacist education needed and how pharmacists can access these eg how to contact physician, how to refer (not necessarily from doctor)
- Education: terminal care (meaning of) (eg drugs needed, sensitivity of them, rapid access required, stags, multiple drugs used for symptom control., delivery, supply of drugs, smooth access to drugs, ease burden, understanding what it’s like for patients in the community, carrying drugs = different for nurses (delivery service from pharmacists).) [to go into ?? introduction and principles of palliative care]
- Relationships with GPs. [to go into working in partnerships and conducting MMRs]
Ideas from PRG, Lit Review & Survey
Introduction and principles of palliative cancer care, including common cancers their incidence and prevalence
Management of cancer pain
Management of non-pain symptoms/side effects
Complementary and alternative medicines and therapies used by patients with cancer (drug interactions)
Access to palliative cancer care medicines and methods of drug administration in cancer treatments (eg morphine 10mg ampoules, 120mg – a big issue; nilstat – supply; 3rd world community availability of drugs – planning for medication supply)
Psychosocial care and communication with patients and families
Working in partnership and conducting medication management reviews to enhance patient care
Using critical reflection to enhance patient care

Group Priorities

<table>
<thead>
<tr>
<th>Nausea and vomiting</th>
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<tbody>
<tr>
<td>What community services provide and how pharmacists can access these</td>
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<tr>
<td>Management of cancer pain</td>
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<td>Psychosocial care and communication with patients and families</td>
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<tr>
<td>Working in partnership and conducting medication management reviews to enhance patient care</td>
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<td>Using critical reflection to enhance patient care</td>
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## Ranking of group priorities

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<th>Totals</th>
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<td>8-8-8-7-8-6-7</td>
<td>52</td>
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<td>Management of non-pain symptoms and side effects</td>
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<td>Introduction and principles of palliative care</td>
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<td>Access to palliative care medicines and methods of administration</td>
<td>5-5-6-2-2-8</td>
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<td>Nausea and vomiting</td>
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<td>Complementary and alternative medicines/treatment</td>
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<tr>
<td>What community services provide and how pharmacists can access these</td>
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</tr>
<tr>
<td>Working in partnership and medication management reviews</td>
<td>1-2</td>
<td>3</td>
</tr>
</tbody>
</table>

Following the answering of question 2, ie going through the identification of key messages under each module topic, the participants realised they did not have ‘working in partnerships’, but that much of what they were putting under ‘critical reflection’ was about working in partnerships – therefore they changed their 8th module to ‘working in partnership’ – see key messages below.

### Eight most important modules [top 8 scores]

- Management of cancer pain
- Management of non-pain symptoms and side effects
- Introduction and principles of palliative care
- Access to palliative care medicines and methods of administration
- Nausea and vomiting
- Complementary and alternative medicines/treatment
- Psychosocial care and communication
- Using critical reflection
Identifying Key Messages in various Modules

Management of cancer pain
- It’s what most people fear
- Education of family/patients re fentanyl patches
- Principles of titration
- Adjuvant drugs in neuropathic pain
- Literature on opioids administration
- Dosage breakthroughs – how is it worked out
- Range of doses required by individuals eg some people may require 1200mg morphine in a syringe driver and multiple drugs needed eg amitriptyline and panadol and education about these
- Most common medications
- Different pain types re cancer
- Pain can increase at end-of-life
- Some drugs can become ineffective
- Opioid rotation: may be complex – need to touch in this
- Person’s drug treatment can affect tolerance
- Administration of medications in palliative care eg Panadol – not to be ‘black and white’ – flexibility and prn medications

Management of non-pain symptoms and side effects (of treatments)
- Symptoms that we’re talking about and education about them
  - Nausea and vomiting
  - Constipation and diarrhoea
  - Oral thrush, ulcers, mouth care
  - Nutritional/food supplements
  - Fatigue
  - Anxiety and depression
  - Terminal restlessness
  - Itch secondary to jaundice
  - Shortness of breath
  - Fungating tumours
Appendix N

- Anorexia
  - Other effective suggestions eg complementary things you can do (non-pharmacological)
  - Palliative care emergencies
  - Anxiety contributes to increased pain
  - Why do symptoms occur re cancer diagnosis – patients need to know and so do pharmacists – refer if serious or new symptoms
  - Combining eg oral thrush and alcohol based mouthwash
  - Refer to doctor if new symptoms
  - Aperients need to be increased with increase in opioids

**Introduction and principle of palliative care**

- Palliative care involves many disciplines and provides holistic care to people with life-threatening illness
  - Inclusion of oncologists and GPs
- Who is in the team?
- Explaining community palliative care and family as unit of care
- It’s not just cancer
- Palliative care is active and dynamic
- Identify uniqueness of it
- Empowering the patient – choice
- A history of palliative care
- What services are available – these are different to each other, what they offer
- Referrals need to be made early not late
- Anyone can refer
- Prevalence and incidence

**Access to palliative care medications and methods of drug administration**

- Educate family on disposal of palliative care medications
- Good understanding of palliative care medications and how they can be administered eg subcutaneous, per rectum
- Delivery of medication at home: storage, family safety (sharps) supply of syringe (1ml) with ordine … - shouldn’t STOP
- Stability of drugs in the home when left in syringes
- Communication of medications not available- to the family
- Communication between pharmacists to access medication/supply
Access to therapy (scripts): faxed scripts – legal issues affecting supply; documentation – how to access more difficult medications in the community eg liaison with hospital; supply
Education re administration of palliative care medications – epidural, intrathecal, portacath, subcutaneous butterfly
Need for supply if patient is on many medications eg given in syringe driver
Advising clients that they can get authority scripts

Complementary and alternative therapies and medicines used by patients with cancer
- Commonly used medications and how they can interact with orthodox medications – especially herbal medicines – legal and illegal
- Resources pharmacists can use
- Aromatherapy
- Vitamins
- Microwave therapy – put tumour in microwave [need to check just what they are talking about eg WA case]
- Coffee enemas – absorption?
- Ukraine treatment – drug via subcutaneous injection - $1,700/injection – imported, internet
- Massage therapists, naturopaths, Chinese medicine practitioners.

Psycho-social care and communication
- Education about community bereavement programs – leaflets, keep it simple – don’t bombard with information
- Listening ear
- Not an alarmist attitude eg on 4 different aperients
- Understand that grief can influence behaviour and communication
- Entitlements: PBS, Safety net – financial issues – who they can refer to
- Carer burden, frustration when patient won’t eat – go to pharmacist to get something eg multivitamins and swallowing issues
- Community resources eg day hospice

[Critical reflection] changed to ‘Working in partnerships’
- Meetings for critical reflection: pharmacists included eg GP, nursing education
- Designated pharmacy on weekends to provide medications
- Communication/contact numbers
- Journaling: health professional
- Pharmacists should feel free to ring other health professionals
- Partnerships
Only time to do the key messages for 7 of the 8 modules

Overall messages
Participants were asked to each state: “If they had one key message that they wanted to get across what would it be?”

- Pharmacists are a key stakeholder in the palliative care team
- Pharmacy sheet: medication list
- If you are not sure, call us!
- Contacts needed: pharmacists numbers, fax numbers (pharmacies in the area and hour of opening)
- Access to drugs and provision of these – sometimes the difference between someone staying at home to die or going to hospital
- Access to medications can be a great carer burden
- Pharmacists should see themselves as part of a multidisciplinary team.
**APPENDIX O: The groups’ decision phase: Nominal groups’ order of priority of modules**

<table>
<thead>
<tr>
<th>Modules</th>
<th>Ranking 8 = most important 1 = least important</th>
<th>Aggregate ranking</th>
<th>Mean value based on number of independent judgements</th>
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</thead>
<tbody>
<tr>
<td>Introduction and principles of palliative care, including common cancers and their incidence and prevalence</td>
<td>6-8-6-8-8-8-8 7-8-8-8-8-8-8 8-6-5-5-3-6-7 8-8-8-8-8</td>
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<tr>
<td>Management of cancer pain</td>
<td>8-7-8-3-7-7 7-7-6-7-7-7-4 8-8-8-7-8-6-7 7-7-7-7-7</td>
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<td>Ethical issues</td>
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<td>Chemotherapy and radiotherapy side effects [was embedded into module 4 and throughout the program where side effects were referred to]</td>
<td>5-5-3</td>
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<td>4.33</td>
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<tr>
<td>Psychosocial care and communication</td>
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<td>88</td>
<td>4</td>
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<tr>
<td>Care of the carer and palliative care worker/team [went into module 1]</td>
<td>5-3</td>
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<tr>
<td>Drug interactions and side effects [was embedded throughout]</td>
<td>6-2</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Modules</td>
<td>Ranking</td>
<td>Aggregate ranking</td>
<td>Mean value based on number of independent judgements</td>
</tr>
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<td>Access to palliative care medicines and methods of administration</td>
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<td>Role of palliative care nurse in the community setting [was included in module 11]</td>
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<tr>
<td>Using critical reflection to enhance patient care [was included in module 1 and embedded throughout]</td>
<td>6-4</td>
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<tr>
<td>Where to go for help – resources [went in module 1 and was embedded where applicable]</td>
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<tr>
<td>Most common cancer drugs used and anything else coming up/side effects of medicines and disease states they impinge on [embedded throughout]</td>
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<td>Familiarisation of well-utilised resources [went in module 1 and was embedded where applicable]</td>
<td>2</td>
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<tr>
<td>Associated pathologies [embedded in module 4 &amp; as side effects]</td>
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</tbody>
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The ‘modules’ column highlights each of the modules, including those identified from previous findings (the literature review and the survey), and new modules identified by the nominal groups. [Comments in brackets] illustrate how the nominal group findings were ‘collapsed’ following review of the NGT findings. The ‘ranking’ column shows how each of the groups ranked each of the modules, from 1 (least important) to 8 (most important). The ‘aggregate ranking’ is the total aggregate of the module rankings from all of the groups. The ‘mean values’ are based on the number of independent judgements made by each of the participants in each of the groups.
APPENDIX P: Module writers guidelines

Module Writers Guidelines

Pharmacists and Palliative Cancer Care

MONASH University

Department of Pharmacy Practice
Revised 13th October 2004
# Contents

**Module Writers Guidelines** ................................................................. 67

**Pharmacists and Palliative Cancer Care** ............................................... 67

**Writers Guide** ...................................................................................... 70

**Introduction** ......................................................................................... 70

- Aims of the Program ............................................................................... 70
- Program Audience .................................................................................. 70
- Time Frame for Completion of the Total Program ..................................... 70

**Philosophy Underpinning the Program** ............................................... 71

- Practice-based ....................................................................................... Error! Bookmark not defined.
- Problem-based ....................................................................................... Error! Bookmark not defined.
- Holistic ................................................................................................... Error! Bookmark not defined.
- Evidence-based ...................................................................................... Error! Bookmark not defined.
- Goal, Audience, Time-focused ............................................................... Error! Bookmark not defined.

**Draft Overview of the Key Messages to Guide Breadth and Depth of Content** .. 73

**The Program Modules at a Glance** ....................................................... 73

**Module 1: Getting the Most from the Program** [1 Hour] ......................... 74

- Key messages .......................................................................................... 74
- Resources within the site .......................................................................... 74

**Information** .......................................................................................... 74

**Case Studies** ........................................................................................ 74

**Learning Activities** ............................................................................... 74

**Self-Assessment Tests** .......................................................................... 74

**Notice Board** ......................................................................................... 74

**Interactive Forums** ............................................................................... 74

**Additional Resources** ........................................................................... 74

- Prescribed texts ...................................................................................... 75
- **Assessment [of the pharmacist’s knowledge]** ........................................ 75
- **Evaluation [of the program content & design]** ..................................... 75

**Module 2: Introduction and Principles of Palliative Cancer Care** [1 Hour] ........... 75

**Module 3: Management of Cancer Pain** [4½ Hours] ............................... 77

**Module 4: Management of Non-Pain Symptoms and Side Effects** [6 Hours] ...................... 78

**Module 5: Complementary and Alternative Medicines Used by Patients with Cancer** [1½ Hours] 79

**Module 6: Methods of Drug Administration** [1 Hour] ............................ 80

**Module 7: Access to Palliative Cancer Care Medicines** [1 Hour] .................. 81

**Module 8: Psycho-Social Care** [1 Hour] ............................................... 82

**Module 9: Communication with Patients, Carers and Families** [1 Hour] .......... 83

**Module 10: Ethical Issues** [1 Hour] ....................................................... 83

**Module 11: Working in Partnerships** [1 Hour] ....................................... 84
Writers Guide

Pharmacists and Palliative Cancer Care

Introduction
Thank you for joining the Program as an expert writer. This information package has been provided to assist you in writing to meet the aims of the program, the needs of the audience and the timeframe for completion of the Program.

The educational program and its evaluation are part of a major research project. Accordingly, the Program content and design has been informed by:
The literature on palliative cancer care and community pharmacists
A survey of the topics community pharmacists felt needed to be included in the Program, and their perceived level of knowledge about a number of palliative care topics
Focus group feedback on priority content areas from palliative care specialists: Doctors, hospital pharmacists, nurses, and community pharmacists.

Aims of the Program
- To increase awareness among community pharmacists of the role of palliative cancer care as an integral part of the health care system and of the role of community pharmacists in delivery of medication management as part of palliative cancer care services
- To improve access of people in metropolitan and rural communities to effective palliative cancer care services
- To enhance the knowledge and skills of community pharmacists in medication management to allow them to work collaboratively with other members of the healthcare team, including palliative cancer care specialists, hospital pharmacists, nurses, and general practitioners
- To provide the educational base for the development of palliative cancer care as a specialised professional service provided by community pharmacists who would work in collaboration with palliative cancer care specialists, hospital pharmacists, nurses, and general practitioners
- To evaluate the impact of the educational program on the knowledge and skills of community pharmacists and on the management of a group of palliative cancer care patients receiving their pharmaceutical care through community pharmacy

Program audience
Busy practising community pharmacists, in both urban and rural areas of Australia.

Time frame for completion of the total Program
20 hours, over approximately three months. Accordingly, each module has been allocated a time frame for completion, to guide the writer when developing the module.
Philosophy underpinning the Program
Writers need to ensure the following elements underpin their writing.
Practice-based
Problem-based
Holistic
Evidence-based
Goal, audience, time focused

Practice-based
The research that informed the development of this Program revealed that the majority of community pharmacists knew little about palliative cancer care needs and medicines, however, this program is not designed to teach everything about palliative cancer care.

All pharmacists have direct access to the Australia Medicines Handbook and the Therapeutic Guidelines Palliative Care (new ones due 2005) and the Therapeutic Guidelines Pain Management. Utilisation should be made of these texts by the writer with particular identification of key points and areas of controversy.

Web site links are encouraged for information, for example Palliative Care Australia and the various Palliative Care Associations in each State and Territory. In addition, the Cancer Council sites contain various research-based guidelines. You may choose to refer to these where appropriate.

Write a list - in point form - of the things you want to say. Check your written content against this list and remove anything that doesn’t need to be there.

The program content needs to be covered only to the depth that is suitable for busy, practising pharmacists.

The content needs to focus on key messages for the types of problems, or symptoms with which patients may present at a community pharmacy.

Reduce content to 5 to 10 need-to-know dot points or practice points. If you had 10 minutes to get the point across to the pharmacist – what would you say about that area and how would you write it?

Keep text (reading information) to a minimum – depending on the topic covered.

Use case studies/examples, activities, quick check self-assessment exercises, communication with others eg by encouraging posting to the Notice Board, or to Interactive Forums, to assist effective and time efficient learning.

Module design will vary, however the following points will assist you in deciding what areas to include, or to what other modules you may make a link. Those showing an * will need to be included in all modules:

Key messages*
Pharmacological interventions
Non-pharmacological interventions
Prescribing points
Practice points*
Adherence issues
Contraindications
Drug interactions, including with food
Adverse effects
Financial considerations
Ethical issues
Psycho-social considerations
Administration instructions
Assessment points
Patient counselling
Continuity of care/working in partnership issues
Screening considerations
Nutritional aspects

Use web links or further reading resources for the ‘nice to know’.

**Problem-based**
Present real-life cases. Patients presenting in health care situations for example community pharmacies, rarely present with simple, easy to solve problems or issues. There is rarely one ‘right’ way of doing things.

Case studies, supported by appropriate information, resources, activities and self-tests will enable participants to:
- Identify what they need to know
- Find the information out for themselves
- realise that there are times when they need to share ideas and seek consultation or collaboration with others.

**Holistic**
Case studies etc need to encompass the whole person and the multitude of problems, symptoms and medicines they may be prescribed, or taking.

Family/carer issues also need to be included where appropriate.

These case studies may link to modules other than the one you are writing. See *The program modules at a glance*.

**Evidence-based**
Content within the topics need to be based on the best available evidence at the time of writing.

Where expert opinion is used, the basis for the opinion(s) needs to be substantiated.

Where differences in the evidence and / or opinion in treatment/management options exist, advantages and disadvantages of the different treatment options, with rationales, need to be discussed.

The pharmacists need to be referred to appropriate resources to enable them to problem solve in the practice situation.

Resources, especially those used from the web, need to have been evaluated by the writer as based on evidence.

**Goal, audience, time-focused**
The overall aim of the Program is to increase the community pharmacist’s knowledge about palliative cancer care – it is not to teach them everything about palliative cancer care.

Two groups of community pharmacists will be participating in this Program:
- Those who completed surveys throughout urban and rural Australia
- Those in western metropolitan Melbourne, as part of the implementation trial

It is envisaged however, that following evaluation and revision of the Program, it may be available nationally.

Many community pharmacists will be business owners as well as practising pharmacists, and will therefore require information and resources to assist their decision making skills during a busy, long, working day.
The Program is 20 hours long. To be complete at a rate of about 2 hours per week, over a 3 month period of time.

To guide the breadth and depth of your writing, each module has been allocated an approximate time for completion, and key messages have been provided.

DRAFT Overview of the Key Messages to guide breadth and depth of content

The information below is the result of input by focus group and project reference group members.

Some of the statements that reflect myths have been left in to enable you to address these.

The aim of the key messages is to guide the program writers. A useful question to assist in determining the key messages is:

“If you only had 10 minutes to get your message across to a community pharmacist about a module topic, what 5 key points/messages would you say?”

Writers are encouraged to review the key messages provided for the module they are writing, and offer any suggestions based on their own expertise: Changes to wording, additions, deletions etc.

The program modules at a glance

Module 1: Getting the most from the program [1 hour]
To include ‘reflecting on practice’, which will underpin the program

Module 2: Introduction and principles of palliative cancer care [1 hour]
To include incidence and prevalence

Module 3: Management of cancer pain [4½ hours]

Module 4: Management of non-pain symptoms and side effects [6 hours]

Module 5: Complementary and alternative medicines used by patients with cancer [1½ hours]
Therapies and dietary supplements to be included

Module 6: Methods of drug administration [1 hour]

Module 7: Access to palliative cancer care medicines [1 hour]

Module 8: Psycho-social care [1 hour]

Module 9: Communication with patients, carers and families [1 hour]

Module 10: Ethical issues [1 hour]

Module 11: Working in partnerships [1 hour]
To include medication management reviews

Total = 20 hours of pharmacists’ time to complete
Module 1: Getting the most from the program  [1 hour]

Key messages
1. Finding your way around
2. Finding the time
3. Critical reflection and analysis of practice
4. Resources within the site

Resources within the site

Information
Evidence-based key information – with case studies, activities, practice points etc interspersed.

Case studies
Clinical Case studies throughout the program need to have links to incidence & prevalence of the cancer being discussed, its causes, diagnosis, stages & cancer treatments. This may be in table format and linked to, eg the glossary.

The common cancers, their signs & symptoms, natural history, prognosis and management will also be embedded into the various case studies, & linked to relevant information.

We are proposing that 4 to 5 case studies, covering the common cancers be developed that filter throughout the program.

Case studies to link throughout the entire Program eg Mr Smith – whose pain you were managing in Module 3, may be re-introduced in Module 4 – discussing his symptom management, psychosocial issues later, and so forth. Need to refer periodically to ethical issues, working in partnership etc. Links would be made at the first introduction, to the various other Modules.

Areas such as access to medicines, psychosocial issues, working in partnership and critical analysis can be embedded into comprehensive case studies and linked to relevant modules.

Learning activities
These will vary. Where possible encourage critical reflection & analysis, exploration of ethical issues, access issues and working in partnership approaches.

Self-assessment tests
For example multiple choice questions, critical reflective exercises, with suggested answers provided by link.

Notice board
Encouragement and space provided to comment about the content, with the option of submitting the comment to the Notice Board. When participants submit to the notice board, they get to view other participants' comments about the topic.

Interactive forums
Online discussion and responses, with moderator input. Other specialists eg doctors, nurses, other pharmacists to also interact in specific areas.

Additional resources
Reading materials eg journal articles etc and web resources.
Prescribed texts

- Australian Medicines Handbook (AMH)
- Therapeutic Guidelines Palliative Care (new edition to be released in 2005)
- Therapeutic Guidelines Analgesics
- The Guidelines for a palliative approach in residential aged care (released May 2004 may be useful for those pharmacies who provide services to residential aged care facilities – these guidelines are freely available from the Commonwealth Department of Health and Ageing [1800 020 787] and are also available on the web: www.palliativecare.gov.au)

Assessment [of the pharmacist’s knowledge]

Assessment of pharmacists’ knowledge before and after completion of the Program is part of the implementation trial.

Evaluation [of the program content & design]

Evaluation of the Program can occur as participants are working through the program, by providing a mechanism for them to comment.

Module 2: Introduction and principles of palliative cancer care [1 hour]

Key messages

1. Introduction
2. Palliative care encompasses more than cancer care; includes a variety of end stage conditions
3. Palliative care is holistic
4. Palliative care is about symptom control not cure
5. Suffering encompasses more than pain
6. Palliative care involves many disciplines
7. Palliative cancer care involves navigating various options in cancer care
8. Palliative care involves managing the self as well as the patient and their carer/family
9. Palliative care, where possible, should be based on evidence

Introduction

Set the scene regarding palliative cancer care
Put PC into the context of community care – statistics on how many patients being cared for at home
Emphasise:
- Symptoms, as this is what community pharmacists will be presented with
- The unpredictability of how the disease will progress
- The individual nature and progression of the disease
Prevalence and incidence, Prognosis and duration – issues around definitive diagnosis eg. don’t always have a definite diagnosis ie treatment based on tissue diagnosis versus clinical diagnosis
Most common types of cancer, Types of patients, age of patients
What is palliative care? What does it mean for patient and family?
“Small things do make a big difference” response to patients/carers, attitudes
Palliative care is complex and messy, but gratifying if put time into it – added from review of overall messages process
Confidentiality – who can you discuss the patient with? - added from review of overall messages process

Palliative care encompasses more than cancer care; includes a variety of end stage conditions

Scope of palliative care, HIV/AIDS, Non-malignant cancer care. It’s not just cancer, Life-threatening disease.
Broad definition of palliative care - not just final stage - could be couple of years after curative stage - not just terminal eg COPD.
Side effects can vary: moderate/severe/life threatening
**Palliative care is holistic**

- Provides holistic care to people with life-threatening illness
- Holistic care ‘whole’ key! – not just 1 discipline - whole team - patient has various key players at different times of the disease process
- Client is main focus: listen to client/carer
- Understanding from patient’s perspective – who’s interests are we serving?
- Explaining community palliative care and family as unit of care
- Identify uniqueness of it - pharmacists need to understand the complexity of the patient and their situation, ie uniqueness
- Empowering the patient choice
- A history of palliative care
- Timely provision of medications to the palliative care client can be the difference between them being managed at home successfully or having to become an inpatient – the pharmacist plays a very important role in the timely provision of these medications
- May involve management of comorbidities as well as cancer symptoms/treatment/effects - added from review of overall messages process

**Palliative care is about symptom control not cure**

- Excellent symptom control not cure
- Palliative care is not equal to Terminal care
- Aim is not to cure
- Concept of total pain/suffering (Saunders, c. (Adrian)
- Quality of life issues goal of care and should inform all decision making
- Good symptom management - palliative care is palliative not curative, managing symptoms
- Disease progression: poor/unwell/dead and opportunities to treat patient along the journey to make them comfortable
- Education of clients/carers on what to expect re treatment
- Best outcome short term
- Monitoring side effects and liaising with doctors as necessary
- Quality of life not quantity - good symptom management = quality of life
- Palliative care though, is consistent with prolonging life

**Suffering encompasses more than pain**

**Palliative care involves many disciplines**

- Not all palliative care is done by specialists - inclusion of oncologists and GPs
- Who to refer to - Who is in the team?
- Knowledge of psycho-social supports available eg community hospice service
- Knowledge of community supports
- Don’t be afraid to ask a 2nd or 3rd opinion/ further opinion
- Support services available disease-related and palliative care combined

**Palliative cancer care involves navigating various options in cancer care**

- Treatment: chemotherapy, radiotherapy, hormonal etc eg bone metastases - types of palliation [this does not require a lot of information, only an overview that there are different treatment regimes such as chemo etc.- may refer to other resources to look up in own time]
- Evolving medicines used in aged care facilities and practical issues eg frequent changing of packaging eg blister packs
- Palliative care is active and dynamic
- What services are available in the community - these are different to each other, what they offer
- Referrals need to be made early not late
- Anyone can refer
- Availability and accessibility open to anybody
- Knowledge of preventing common problems, and if can’t prevent, what are their treatments
- Palliative care is different to any other disease state and there are a lot of people involved
- Being aware of who local oncologists are and where local chemo treatment centres are
- Country areas: who would they tap into?
- Being aware that client is having some form of these treatments
Awareness of drug interactions – may have several links throughout – that link to a table of known drug interactions

**Palliative care Involves managing the self as well as the patient and their carer/family**

Brings up own feelings of vulnerability, anxiety have to deal with these, not add to patient’s/family’s

**Palliative care should be based on evidence**

Research issues [note the difficulty in doing research into PC treatments and PC itself, as much of what practitioners do does not provide level 1 evidence – pharmacists just need to be aware of the dilemmas – this may also link with use of unlicensed use of drugs as well]

**Module 3: Management of cancer pain [4½ hours]**

**Key Messages**

1. Pain is what most people fear - Pain disrupts day-to-day living and keeps reminding the patient that the disease is active
2. Assessment is crucial: Need to recognise poorly managed pain
3. Palliative cancer care requires complex pain management alternatives
4. Need to treat the side effects of treatment and medications as well as the treating pain
5. Need to educate patients and their carers/family
6. Need to dispel morphine phobias

**Pain is what most people fear**

- Pain is a highly subjective and individual experience
- There are different types of pain that require complex pain management strategies - tissue, neuropathic, psychological, physical, emotional etc - Emotional pain and refer to counsellor
- Explanation of pain pathways and analgesic use
- Pain can increase at end-of-life
- Pain is what the client says it is
- Linked closely with quality of life
- Determine pain threshold indirectly or directly
- Pain must go away

**Assessment is crucial: Need to recognise poorly managed pain**

- Recognition of poorly managed pain and associated issues of assessment and reasons
- Critical review of pain control monitor, who is monitoring?
- Poorly managed pain may contribute to depression and suicidality - added from review of overall messages process

**Palliative cancer care requires complex pain management alternatives**

- Aim for patient comfort – remove pain and make the patient and family feel comfortable
- Principle of cancer pain management prn, Principles of titration – pharmacists on their own out in the community need reassurance on dosages – how to convey/explain dosage escalations to the carer/family without sounding negative – [this point will probably link with module on 'communication with patients/families]
- Most common medications (eg morphine, hydromorphone, oxycodone, fentanyl, methadone, ketamine) and side effects of drugs used
- Some drugs can become ineffective
- Opioid rotation: may be complex need to touch on this - Opiate dose conversion - Importance of regular dosing not prn dosing
- Dose just sufficient to decrease pain
- Dosage breakthroughs how is it worked out
- Person’s drug treatment can affect tolerance
- Administration of medications in palliative cancer care eg paracetamol dose not to be ‘black and white’ flexibility and prn medications
- Emergency top-up treatment when and where escalating treatment
- Drugs available / approaches to pain management - Treatments used and alternatives
- Mechanistic approach to pain and multi-modal treatment
Role of chemotherapy and radiotherapy treatments in pain management

Neurophysiology

Classes of analgesics

Adjuvant use - Adjuvant drugs in neuropathic pain - Need to use adjuvant medications with pain medications tegretol, dexamethasone, panadol, voltaren etc are OK to use

Dosage form alteration

Range of doses required by individuals eg some people may require 1200mg morphine in a syringe driver and multiple drugs needed eg amitriptyline and panadol and education about these

Need to treat the side effects of the medications as well as the treating pain

Plan and implement strategies to decrease the adverse effects of eg opioids; sedation, nausea and vomiting, constipation; and appropriate medications to treat these

Opioids and toxicity (link to non-pain symptoms)

Literature on opioids administration

Need to educate patients and their carers/family

Eg re fentanyl patches

Awareness of drug interactions – may have several links throughout – that link to a table of known drug interactions

Need to dispel morphine phobias

eg cultural, educational – some health professionals who don’t know about palliative care and doses used; beginning of the end; drug of choice because has no ceiling – ceiling doses – confusion

There is no standard dose for morphine ??

Possibility of good analgesia being achieved, dispel myths

Who cares about addiction? Is addiction even possible? Doctors afraid to order morphine etc; some nurses/pharmacists afraid of addiction if not educated in palliative care - without maxalon can leave patients with bad experiences: need education

Fear that tolerance will develop and there will be none left for the end of life when myth says pain gets worse [note use of different terms among the groups ‘addiction’ ‘tolerance’ and how these differ etc]

Module 4: Management of non-pain symptoms and side effects [6 hours]

Key messages

1. Recognising, monitoring and managing common symptoms will decrease distress

2. Management and medication management of common symptoms

3. Common symptoms encountered by pharmacists: Shortness of breath, nausea and vomiting, mucositis, constipation, confusion, anxiety, depression, terminal restlessness, fungating wounds

4. Patients may present with multiple comorbidities

5. Community pharmacists’ may help prevent palliative care emergencies

Recognising, monitoring and managing common symptoms will decrease distress

[need to determine which are the most common symptoms that pharmacists will be presented with at the pharmacy eg review those with a **]

Minimise distress to patients and carers by appropriate and timely treatment of symptoms

Why do symptoms occur re cancer diagnosis - patients need to know and so do pharmacists - refer to doctor if serious or new symptoms

Common symptoms - Symptoms that we’re talking about and education about them - Prevalence and impact of these

**Nausea and vomiting

**Shortness of breath - Respiratory function - Dyspnoea and opiates

** Specifics of constipation in palliative care - Bowel management - diarrhoea -

**Confusion - Delirium

**Terminal restlessness

**Wound care: Pressure ulcers - Skin and pressure care - Itch secondary to jaundice

Oral thrush, ulcers, mouth care - Mouth care products - Combining eg oral thrush and alcohol based mouthwash
Appendix P

Anorexia
Swallowing difficulties {can be linked to ‘methods of administration’}
Aperients need to be increased with increase in opioids - bowel obstruction
Anxiety and depression - Anxiety contributes to increased pain - Appropriate diagnosis and use of appropriate medicines eg in depression/anxiety
Generalised effects of cancer weight loss, cachexia, deconditioning
Fatigue - no medication for
Sleep problems
Fungating tumours
Mobility
Symptom management: that’s what nurses do
Small things can make a big difference – fine tuning re medication management – added from review of overall messages process

Management and medication management of common symptoms
Importance of monitoring and reviewing client
Other effective suggestions eg complementary things you can do (non-pharmacological) - link to CAMs module

Patients may present with multiple comorbidities
Patient may be experiencing more than cancer - pts may have other active disease states
Diagnostic approach to non-malignant symptoms
Being aware and having knowledge of other medical conditions eg diabetes
Managing side effects of drug treatment
Common to have multiple symptoms – metastases, side effects
Awareness of drug interactions – {may have several links throughout that link to a table of known drug interactions}

Community pharmacists’ may help prevent palliative cancer care emergencies
Palliative care emergencies
Need to act quickly to prevent serious outcomes eg hospitalisation
Emergencies - what constitutes one?
Emergency top-up treatment – when and where – escalating treatment

Module 5: Complementary and alternative medicines used by patients with cancer [1½ hours]

Key messages
1. Ensure own views do not disempower the patient and/or their carer/family
2. Pharmacists need to know what complementary and alternative medicines are being used by patients
3. Monitor effectiveness of dietary supplements in palliative cancer care
4. Recognise that there are alternative therapies that may assist pain relief and increase the comfort of patients
5. Base advice on current evidence

Ensure own views do not disempower the patient
Non-prejudicial - as they could be a threat to pharmacists - explore; non-judgemental; not disempowering the client: it’s their choice and responsibility
Patient/family have opportunity to voice that - to refuse medicines (? into intro, may also link with ethical issues) - Duty of care issues
What motivates people with cancer to use CAMs?
Consultation with CAM practitioners

79
Pharmacists need to know what complementary medicines are being used by patients
What is the difference between ‘complementary’ and ‘alternative’ treatments, where do they fit in? allied health etc - Various treatments available: complementary and conventional - look at cost
Need to be aware of interactions between prescribed medications and CAM treatments
Commonly used CAMs and how they can interact with orthodox medications, especially herbal medicines - legal and illegal - Interactions with conventional medicines
Being able to communicate with clients that they are taking CAMs
Making sure doctors and oncologist aware of what patients are using eg that patients are having eg massage -possibility of spread
Use of CAM may be a lost opportunity to treat

Monitor effectiveness of dietary supplements in palliative cancer care
Current evidence in the literature - home/diet/nutrition
Dietary supplements especially for constipation
Different types of supplements eg Anti-oxidants and vitamins
Alright not to eat today
Impact of dehydration
Role of enteral nutrition, interactions
Palliative care at end-of-life - when is it appropriate to withdraw dietary supplements
How long to treat with CAM without changing outcome

Be aware of alternative therapies that may assist pain relief and the comfort of patients
Simple treatments the pharmacist can recommend eg massage (caution – spread of cancer), aromatherapy, music therapy, reiki, hand and foot massage
Alternative treatments being offered in the local area
Other modalities eg music therapy
Naturopaths, Chinese medicine practitioners.

Base advice on current evidence
Need for evidence based information - where possible
Resources pharmacists can use
Legal professional responsibilities - where do you draw the line? Knowing your practices/protocols {may link to ethical issues}
Role of CAMs in palliative cancer care not clear as people tend to look at CAMs for treatment rather than palliation
What do patients use - folk law, coffee enemas, juicing - how it impacts on pharmacists role
Microwave therapy - put tumour in microwave [??? need to check just what they are talking about eg WA case]
Ukraine treatment - drug via subcutaneous injection - $1,700/injection - imported, internet

Module 6: Methods of drug administration [1 hour]

Key messages
1. Supply appropriate products/equipment and information for the delivery of palliative cancer care medicines, by a variety of routes
2. Provide information on storage, safety and disposal of used medicines/products

Supply appropriate products/equipment and information for the delivery of palliative cancer care medicines, by a variety of routes
Good understanding of palliative cancer care medications and how they can be administered eg subcutaneous, per rectum, NG etc - what can be crushed, what can’t – be aware that medicines are crushed, because the person can’t swallow, but also when patients refuse medicines (link to ethics)
Education re administration of palliative cancer care medications - epidural, intrathecal, portacath, subcutaneous butterfly
Drug routes available in the community - will nurses give IV or not? Syringe drivers available in the community
Knowledge of drugs and methods of administration: high doses used - good to have the dosages ordered there for support, that not to have them ordered and need them

**Provide information on storage, safety and disposal of used products and unused medicines**
Delivery of medication at home – storage, family safety (sharps) supply of syringe (1ml) with ordine … - shouldn’t STOP
Educate family on disposal of palliative care medications - Disposal of unused medications - given to nurses often
Stability of drugs in the home when left in syringes

**Module 7: Access to palliative cancer care medicines [1 hour]**

**Key messages**
1. Ensure timely access to prescribed medicines
2. Communicate and collaborate with others to ensure access and uninterrupted supply of medicines
3. Consult with GPs re off-label use of medicines

**Ensure access to prescribed medicines**
Access to drugs and provision of these – sometimes the difference between someone staying at home to die or going to hospital (may link to ethics, psycho-social care)
Access to drugs can be a great carer burden (may link to ethics, psycho-social care)
Knowing how to apply for non-PBS medications - bulk supplies
Communication of medications not available- to the family and to other health professional so that alternatives can be arranged (may link to working in partnership and communicating with pt/carer/family)
Communication between pharmacists to access medication/supply
Current regulatory system in Australia including SAS
Medicine importation
Difficulty accessing old medications or medications currently marketed for another indication
Problems with payment under the Pharmaceutical Benefits Scheme (PBS) for palliative care patients and payment for pharmacists for non-PBS meds – may feel awkward – may be real financial hardship - added from review of overall messages process
Off-label and control trial prescribing

**Communicate and collaborate with others to ensure access and uninterrupted supply of medicines**
(may link to working in partnership)
Access to therapy (scripts): faxed scripts - legal issues affecting supply; documentation how to access more difficult medications in the community eg liaison with hospital; supply
Good access to available medications - prescription not filled at pharmacy, especially on weekends especially if have pain; pharmacists: where can they get it quickly from elsewhere?
Some pharmacists can get it from places and some can’t eg Dilaudid
Advising clients that they can get authority scripts
Need for supply if patient is on many medications eg given in syringe driver
Availability of medications is especially important out of hours
Being aware of client’s palliative care state so pharmacists can get medications they may need in good time
Ongoing liaison with pharmacy: supplies of medications
Planning for anticipated needs eg get medications in home before they’re needed
Costs to clients - not only paying for medications - being aware - expensive medications especially if changing medications

**Consult with GPs re off-label use of medicines**
(may link to working in partnership)
Cost
Availability
Legal issues
Module 8: Psycho-social care [1 hour]

Key messages
1. Cancer and psychological distress have a social impact on the patient and their carer/family
2. Patients are at risk of complicated grief, depressive disorders and suicide
3. Cultural background impacts on the delivery of palliative cancer care
4. Time is required for care

Cancer and psychological distress have a social impact on patient and family
- Broad social impact - family, finances, sexuality, religion
- Spiritual distress in secular community
- Stigma associated with heavy opioid use
- Entitlements: PBS, Safety net - financial issues - who they can refer to (link to access of medicines)
- Monitor coping at home (families) and refer as necessary
- Important to keep treatment regimens in context of clients/carers and their individual situation: one solution doesn’t fit all
- Awareness of not only physical aspects spiritual and psycho-social - holistic
- Counselling tools
- Moving into and out of care and respite for carers
- Carer support - where, when, who and importance of utilising supports
- Physical and psychological comfort aspects
- Care for the carer
- Treating more than one person (may link to communication with pt/carer/family)
- Self-concept, body image and sexuality – stigma, guilt and shame affecting patients and family
- Relationship issues
- Practical and financial issues – eg costs, loss of income, travel and accommodation for treatments etc

Patients are at risk of complicated grief, depressive disorders and suicide and their feelings have an impact on the carer/family
- Recognition and knowledge of depression/anxiety. Delirium - impact on family etc
- Understand that grief can influence behaviour and communication
- Carer burden, frustration when patient won’t eat - go to pharmacist to get something eg multivitamins and swallowing issues
- It’s OK to go through a range of emotions - anger, sad, fear
- What is grief and bereavement (not necessarily at the time of death)
- Prognosis and acceptance
- Care of family members after bereavement
- Helping re disposal of excess meds and devices etc (may link to methods of drug administration)

Cultural background impacts on the delivery of palliative cancer care
- Cultural issues - impact on family, decision making (both ways ie cultural issues of pharmacists/health professional as well as cultural issues of patient/family)
- Forming a treatment team and importance of communication - ensure approaches are similar among health professional team as well as with patient and family as part of the team
- Language, cultural background and beliefs - need to be in pain: part of some cultures, still living if in pain; interpreter
- Ability to read label on medications
- Some cultures will only listen to information from a male - what to do if you are female
- Understand that some of the cultures have different beliefs about medications
- Who’s the decision maker in the family - culture

Time is required for care
- Effective empathic communication skills (link to communication with pt/carer/family)
- Education about community bereavement programs - leaflets, keep it simple - don’t bombard with information (link to communication with pt/carer/family)
- Listening ear - Taking time to listen (link to communication with pt/carer/family)
Community resources eg day hospice
Access to counselling for patients/family if needed
Knowing who is involved in client's care: other health professionals, not doubling up - (link to working in partnerships)
Availability of support services (link to working in partnerships)
Being aware of community resources and how to access them – refer (link to working in partnerships)
Involvement of schools and churches - volunteer organisations (link to working in partnerships)
Holistic care
Organisations who can assist with psycho-social aspects - a list eg church, social workers (link to working in partnerships)
Who to talk to and privacy issues associated with it (link to working in partnerships)
Who you can go to for help in the team (link to working in partnerships)

Module 9: Communication with patients, carers and families [1 hour]

Key messages
1. Good communication can positively affect psychosocial and physical status of the patient and their carer/family
2. In palliative cancer care there is often a need to ‘speak the unspeakable’

Good communication can positively affect psychological and physical status of the patient and family/carer
If communication isn’t clear in easily understood language can lead to distress and treatment failure (may link to non-pain symptoms)
What each medicine is used for - explain (detail) to patient/carer - confidentiality issues – who to tell? (link to ethical issues)
Use of interpreter (link to working in partnerships)

In palliative cancer care there is often a need to ‘speak the unspeakable’
What patients/family want and need to know - what to tell them (link to ethical issues)
Communication with a patient who doesn’t know the diagnosis (link to ethical issues)
Not an alarmist attitude eg on 4 different aperients

Module 10: Ethical issues [1 hour]

Key messages
1. Introduction to principles of human healthcare ethics
2. Personal values and beliefs affect ethical decision making
3. Clinical pragmatism and its use in palliative cancer care

Introduction to principles of human healthcare ethics

Personal values and beliefs affect ethical decision making
Compassionate costing - treatment/products and recommendation of products
Evidence based practice (link to Access to meds)
Being comfortable when dealing with pharmacological uncertainty
State/territory laws differ
Approaches to suspected misconduct by a team member/patient/family
Importance of out-of-hours access

Clinical pragmatism and its use in palliative cancer care
Clinical pragmatism - embedding ethical theory in clinical practice with an overriding concern with context
Sedation and end-of-life and relationships to euthanasia and physician-assisted suicide
Understanding double effect/causality
Decision making around NFR / treatment withholding/discontinuing
Appendix P

Total symptom control at any cost - social, financial etc [?] Meaning as during the validation process one focus group member raised need to clarify, as open to misinterpretation – nothing further stated in the transcript to provide clarification of meaning – possibly about: while total symptom control may be the ideal, at any cost, the decision needs of be made by the team in consultation with the patient/carer/family
Cultural, social and religious issues - when patient doesn’t want to know

Module 11: Working in partnerships [1 hour]

Key messages
1. A partnership approach enhances patient care
2. Educating families to be independent with some of their care is important
3. Pharmacists should ring other health professionals
4. Review and assessment of the effectiveness of medicines is crucial
5. Reviewing one’s own practice is important for evaluating the partnership approach

A partnership approach enhances patient care
List of all health providers associated with every patient - Communication/contact numbers eg specialists, family members
Care of the palliative care team
Meetings for critical reflection: pharmacists included eg GP, nursing education
Partnerships - Designated pharmacy on weekends to provide medications (link to access)
Coordinating care in community between local medical officers, physios, OTs, oncologists etc - not case managers - How to access others - referral process
Awareness of patient/family dynamics (link to psychosocial care)
Overcoming barriers of privacy legislation
Communication with locum pharmacists, continuity of care between pharmacists

Educating families to be independent with some of their care is important
Eg diabetes: blood sugars; injections; personal care/hygiene; tending wounds; morphine: administering

Pharmacists should ring other health professionals
Ensure patient provided with knowledge of partnerships - Who knows what?
Liaison between palliative care workers
Acknowledgement of each others strengths, weaknesses and roles in the palliative care team
Knowing your hospital pharmacists
Who, what, when of palliative care - pharmacist should be aware of how to access local palliative care nurses - Palliative care district nurses are a valuable resource - Provide hands-on nursing care varies form service to service eg consultancy services hours of service on-call
Palliative care nurses have most contact with client for monitoring and management
The pharmacist is a valuable resource for knowledge of medications, methods/routes of drug administration that the nurse can tap into
Liaison person/member supporting family in community
Link between patients and pharmacy
Advocate for patient

Review and assessment of the effectiveness of medicines is crucial
Medication management reviews
MMRs for palliative care patients aren’t outside the norm
Need to be identify eg if person on dexamethasone and not on any
Zantac or Losec, or, people on 3 or 4 different drugs of the same class eg benzos – when giving one better etc]
Reviewing own practice is important for evaluating the partnership approach

Critical reflective practice (link to Module one)

Case studies

A 28 year old single woman who presented with severe right jaw and face pain (link to pain management). Twelve months prior she had been diagnosed with a right-sided carcinoma of the tongue (link to incidence and prevalence). She underwent surgery (partial excision) and radiotherapy to the involved lymph node groups (Link to negotiating treatment options). She was disease free and well, living interstate until a couple of weeks ago when she started complaining of pain. She was biopsied and diagnosed with recurrent disease in her tongue and adjacent lymph node groups. She returned home to be with her mother (link to psychosocial).

Her speech was affected by immobility of her tongue as was her ability to swallow (link to non-pain symptoms). As a result she had a Percutaneous Entero-Gastroscopy (PEG) tube inserted via gastroscopy in order to provide nutrition and as a way of giving oral medications (link to methods of drug administration).

She described two pains: a dull, aching, constant pain near the angle of her right jaw radiating down into her neck. The second pain was a sharp, electric-shock like intermittent pain lasting seconds involving the right mandible to the level of the incisors. She also noted a hypersensitivity in the skin over the area of her right mandible (link to pain management).

Initially she was admitted as an emergency, for pain management and rehydration. The pain was described as severe rating 8-9 out of 10. Initial analgesia was 7.5mg morphine subcutaneous (S/C) every 4 hours with 5mg morphine S/C as breakthrough up to every hour if required (refer to AMH reference). Her renal function was normal and her hydration was being corrected. Her conscious state was normal.

The initial dose resulted initially in excellent pain relief (visual analogue pain score fell to 3/10) (link to pain management). She was somewhat drowsy and sleepy which we explained was in part sleep deprivation and in part the initial sedating effect of the morphine which would wear off in a day or two link to pain management}(link to non-pain symptoms). However over the next 24 hours she required frequent breakthrough doses (10x5mg) and the background morphine dose was increased to 10mg S/C 4hourly (link to pain management). Unfortunately she became increasingly drowsy, sedated and mildly delirious (link to non-pain symptoms).

On careful questioning it became apparent that only the dull, aching, constant pain (nociceptive pain) responded well to morphine but that the intermittent sharp, shooting pain (neuropathic pain) did not respond well she fell asleep with the morphine but the pain itself was unaltered, and was the cause of her requesting and receiving more and more frequent breakthroughs of morphine (link to pain management). We therefore commenced her on gabapentin, 300mg three times a day, and this had a dramatic and beneficial effect on the neuropathic pain, such that the dose of morphine was reduced by 50%, she required no breakthrough morphine, and she became much less drowsy and more lucid. Gabapentin was chosen ahead of a tricyclic antidepressant (TCA) for management of neuropathic pain, because of the anticholinergic side effects of the TCAs (in particular dry mouth, in a person already irradiated) (link to off label use or AMH).

After a further 48 hours we converted her to oral morphine, 45mg orally BID and increased the gabapentin to 600mg oral TDS. Her pain was stable (link to pain management).

Case study: Different types of pain

John is a 44 year old man with advanced bowel cancer (link with incidence and prevalence). His pain from the bowel cancer is well-controlled with morphine (refer AMH 2004 xxxx). John is on one of his days out with his wife (link with psycho-social care) and comes into the pharmacy to fill a repeat prescription for morphine. You ask John how he’s been feeling (link with communication module). John describes a terrible pain that he gets down his right leg, but tells you that he doesn’t like to bother the doctor (link with working in partnership). You ask a number of questions (link with communication module), one of which
is for John to describe the pain. John says that the pain comes from nowhere like an electric shock down his leg, and tells you that he is really scared (link with management of cancer pain) of it coming back and so doesn’t sleep well at night (link with management of non-pain symptoms).

(Provide a series of exercises for the pharmacists) eg What would you do?

Ring the doctor (link with working in partnership), discuss the pain with her/him (link with management of cancer pain) – possible neuropathic pain and amitriptyline could be prescribed. This could decrease the pain and assist John in sleeping better.

Case study: More than one pain

Jane Small comes into the pharmacy to fill a script for morphine. You know Jane and Mike well. At 70 years of age, Mike was diagnosed with advanced lung cancer (link with incidence and prevalence). Jane seems especially troubled this visit (link with psycho-social care and carer burden). You ask how things are going. Jane reveals that Mike seems to always be in pain (link with management of cancer pain). She says he has low back pain, gets frequent headaches, has a burning pain in his right arm, and pain in his left hip. He has also started experiencing some abdominal pain and mild nausea (link to non-pain symptom management). Your records show that he recently started taking diclofenac (? Link to MMRs), and Mike has not seen the doctor since he started taking the diclofenac.

(Provide a series of exercises for the pharmacists) What would you do?

On consultation with the doctor (link with working in partnership) you find that the lower back pain is thought to be due to bony metastases in the lumbar spine, and that the pains in the right arm are due to brachial plexus involvement. The doctor suspects that John’s headaches are from his concern for Jane and his family now that his condition is deteriorating, but is open to other suggestions, and that the pain in the hip is due to his arthritis. The diclofenac may be the cause of the abdominal pain and nausea. Etc etc

Case study: Feeding, hydration, delivery of medications and patient and family stress

Mrs James is a 45 year old woman (link to psychosocial issues) with metastatic carcinoma of the breast (link to incidence and prevalence information). She has multiple bone (link to incidence and prevalence information), lung (link to incidence and prevalence information) and liver (link to incidence and prevalence information) secondaries. Pain (link to management of pain) and nausea (link to management of non-pain symptoms) have been major symptoms, but until recently, these symptoms were controlled on MS Contin (link to management of pain) 160mg 12 hourly, and Maxolon (link to management of non-pain symptoms) tablets 40mg q.i.d. Over the past week there has been an escalation of pain, mainly in the lower back, requiring several breakthrough doses of morphine mixture (link to management of pain) per day. The MS Contin dose was increased to 200mg b.d., however the pain persisted, nausea again surfaced, and after 24 hours, the patient started vomiting (link to management of non-pain symptoms). These symptoms persisted over the next 2 days with the patient unable to tolerate food or fluids (link to management of non-pain symptoms), she became very lethargic (link to management of non-pain symptoms) and was unable to mobilise unaided (link to psychosocial care). Over the next 24 hours she became very restless (link to management of non-pain symptoms). The patient’s family; husband and two teenage daughters, became very stressed (link to psychosocial care), and were concerned that Mrs James was not eating or drinking and having difficulty swallowing her medications (link to methods of drug administration). Despite the fact that they wanted to care for Mrs James at home, they were now asking for admission to hospital (link to psychosocial care).

Case study

Mr C. is an 80 year old widower who lives in a local hostel (link with working in partnerships). He has a history of COPD, IHD, Type 2 diabetes [diet controlled] and PVD. He was admitted to the Hostel one year ago following an amputation of his leg. During his hospitalisation there had been an incidental finding of lung cancer (link with incidence and prevalence). He has had no treatment for this because of his co-morbidities.
You are involved with preparing his blister pack for his medications (link with working in partnerships) The hostel manager contacts you for advice (link with communication with patients, carers and their families). The manager is a Division 1 RN but there are no other Division 1 RN’s at the hostel and so medications must be administered from a blister pack. Mr C. is becoming increasingly dyspnœic nocturnally (link with non-pain symptoms) and the local Doctor has prescribed morphine mixture or immediate release morphine tablets to be given as necessary but the staff at the hostel are unable to dispense opioids.

You discuss Mr C.’s ongoing management with the hostel manager and he tells you that Mr C. is determined to remain at the hostel where he has developed close relationships with the staff (link with psychosocial care). The hostel has an ‘aging in place’ policy and have arranged for the community palliative care nurses to assist them in caring for Mr C.

[Exercises for the pharmacist follow in non-pain symptoms management module]

**Case study**

Mrs T. has renal cell cancer, which had metastasised to her lung and bone when she was diagnosed. She presented with a fractured humerus (link with incidence and prevalence). Chemotherapy or surgery was contra-indicated (link to navigating various options in cancer care). Mrs T. had radiotherapy to her bone metastases. She still required SR morphine 60mgs BD and 20 milligrams of morphine mixture for breakthrough pain, (link with management of cancer pain). She was discharged to her daughter’s house because she required assistance with most activities of daily living (link with psychosocial care).

You are her daughter’s local pharmacist and you know her well. The daughter is a single mother with three teenage children (link with psychosocial care). She comes to your pharmacy to fill her mother’s script for morphine mixture and ask advice regarding continence pads. You note she appears tired and agitated to get home and you enquire after her mother and how she is coping (link with communication with patients, carers and their families). Mrs T.’s daughter explains that her mother is very nauseated and unable to eat. She has increasing abdominal pain. She explains her mother has become faecally incontinent and asks your advice for anti-diarrhoeal medicine (you have helped her in the past with appropriate advice for her children) (link with management of non-pain symptoms and side effects). She is in a hurry to get home because her sixteen year old daughter is ‘minding’ her mother and is missing school (psycho-social care).

You note that the script does not have any laxatives or antiemetics prescribed. Mrs T.’s daughter explains that she stopped giving her mother aperients two days ago when the diarrhoea started. When she obtained this script she had plenty of aperients from her mother’s previous hospital discharge medication. She says the metoclopramide is no longer working so she stopped that as well (link with non-pain symptom and side effects management).

You enquire whether Mrs T. has any community nursing support and she explains that the nurses are starting visits the next day (link with working in partnership & psychosocial care).

[Exercises for the pharmacist follow in non-pain symptoms management module]

**Case study**

Mr P. is a 68-year-old man who has metastatic prostate cancer. He has metastases locally and several bone metastases (link with prevalence and incidence). He has had several courses of radiotherapy (link with navigating various options in cancer care) for painful bony metastases (link with management of cancer pain).

Mrs P. has been collecting his script for zoladex for several years now and commented to you when she last collected the script that Mr P’s prostate specific antigen (PSA) test was rising and the cancer seemed to be getting worse despite the zoladex (link with communication with patients carers and families). The oncologists were considering other chemotherapy for him.

Mr P. is on a 75microgram fentanyl patch and takes oxycodone for breakthrough pain (link with management of cancer pain). Mr P. usually accompanies Mrs P to the pharmacy (link with psycho-social care).
This morning Mrs P. comes on her own and enquires about hiring a commode and urinal. She explains that Mr P’s back pain is getting worse and he is having difficulty walking, she thinks because he is needing to take so much oxycodone – ‘He’s all drugged up!’ she says. (link with management of cancer pain). ‘He even wet the bed this morning’ (link with management of non-pain symptoms and side effects). She explains that she thought a day in bed and not having to walk so far to the toilet might improve his pain. He hates hospitals and doesn’t want to bother the Doctors (link with psycho-social care).

[Exercises for the pharmacist follow in non-pain symptoms management module]

Activities throughout the Program

As stated earlier various learning activities will be interspersed throughout the program.

These often become obvious as you write different sections of your module.

Self-assessment tests

For example multiple choice questions (MCQs), critical reflective exercises, with suggested answers provided by link.

Self-assessments are best designed during the writing phase of a program.

If you have never developed these before, just jot down some ideas and the project manager will refine those ideas and turn them into learning activities.

Multiple choice questions for example can be time consuming to prepare properly. See attached information guidelines.

Notice board

Encouragement and space provided to comment about the content, with the option of submitting the comment to the Notice Board. When participants submit to the notice board, they get to view other participants’ comments about the topic.

Interactive forums

Online discussion and responses, with moderator input. Other specialists eg doctors, nurses, other pharmacists to also interact in specific areas.

Web designer’s guidelines

The following are points that should be considered when preparing content modules for the Pharmacists and Palliative Cancer Care Web site.

A. General document formatting

Use Arial, 10 pt, justify text.

B. Use formatting as described

The Web designer will format the content of each document using his own style sheets, consequently most of the Word formatting that you may be using is removed.

Please do not use:

- TABS.
- CRLF (Enter) at any places other than the end of a paragraph.
Please use

- Headings and sub heading in bold.
- Bullets, but these will all be converted to a dot when web published.
- Use tables, graphics - provide any graphics or photographs in ‘GIF’ or ‘JPEG’ format

For example following:

1.2 Learning outcomes

Upon completion of this module you will

- develop an understanding of the role of a preceptor
- clarify your personal expectations of the role of a preceptor

C. Use section numbering.

As you will see in the example below we use section numbering to identify each section and allow people to move between non-sequential content (hyper-linking). It’s very important that you develop your content structure before you start writing so that you can apply your numbering throughout the document accurately. This content structure should be placed at the beginning of each chapter. It will not be used in the final web site so you may use formatting to help you set out the content structure.

The following is a section overview constructed for a module from another program:

Content structure

1.0 Introduction - Roles & Benefits

1.1 Overview
   1.1.1 Key terms and definitions

1.2 Learning outcomes

1.3 Professional roles of a pharmacist and preceptor
   1.3.1 Roles of a pharmacist
   1.3.2 Role of the preceptor

1.4 Goals of preceptorship

1.5 The Impact & Benefits of being a preceptor
   1.5.1 Impact
      1.5.1.1 Impact on the student
      1.5.1.2 Impact on staff
      1.5.1.3 Impact on patients
      1.5.1.4 Your reasons for becoming a preceptor

   1.5.2 Benefits
      1.5.2.1 Benefits of having preparation as a preceptor
      1.5.2.2 Benefits for you
      1.5.2.3 Benefits for the Universities
      1.5.2.4 Benefits for the profession

1.6 Being an effective preceptor
   1.6.1 What makes an effective preceptor? (1)
   1.6.2 What makes an effective preceptor? (2)
1.7 Professional issues impacting on the preceptor role

1.8 Assurance quality of the learning experience

1.9 Learning Summary 1

1.10 References

The actual content will follow in the document using the headings/sub-headings for your own program writing, as above.

D. Start a new page for each Section/Sub-section.
Please start each section/sub-section on a new page.

E. Use {section number} to indicate links.
To indicate to the Web designer that you would like a link to another section.

For example:
An important skill for a pharmacist and any health care professional is the development of clinical reasoning skills (2.4.1.2). The process of clinical reasoning involves constructing reality in a health care encounter based on the influence of previous experiences (7).

This would result in a hyperlink being inserted such that when the underlined text is clicked then the content of section 2.4.1.2 will be displayed.

This also applies to a link to a table or a figure (diagram or visual).

For example:
(Table 1.2) outlines the incidence and prevalence of various cancers. Table 1.2 would be labelled as such, with the appropriate title.

For example:
Table 1.2: Incidence and prevalence of various cancers

Save the visual as a separate file.

Writing conventions and Writing for the Web

Writing conventions
Only capitalise the letter at the beginning of the heading or subheading
Only use capitalisation for the first word of a sentence, after a colon ( : ), and for proper nouns
Do not use full-stops after headings and subheadings
If the list represents a sequential list, use numbers or letters (1, 2, 3 or a, b, c)

Abbreviations, acronyms, terminology or conventions
Ensure correct and consistent use of abbreviations, acronyms, terminology or conventions
The first time these items are used, fully define them for example:

First use: A Video Cassette Recorder (VCR) is the . . . .
Subsequent use: The VCR can also . . . .

Slang or jargon should be avoided
Grammatical conventions for this program
Use the generic (or active ingredient) name for all medicines
Use Australian English
Use ‘s’ instead of ‘z’ for example organisation, stigmatisation, except where American English is used in any direct quotes

How people read the from the web
Most people do not read word-for-word when reading online. They scan. Web readers are also likely to skip or ignore large chunks of text, or content that is not relevant to their immediate goals.

Therefore:
   Be concise
   Use clear and plain English language
   Organise information into clearly labelled, short ‘chunks’ of content-relevant information
   Use tables, graphics, photographs, cartoons etc, where these enhance the reader’s understanding of the topic

Use plain English language
Plain English language emphasises the reader – not the writer, and not the message.

Aims:
   Engage the reader
Use:
   Pronouns such as “you” “we” whenever appropriate
   Refer to the patient (instead of client/consumer) and the Program (instead of course) where appropriate
   Familiar, everyday words:
      Buy, instead of acquire
      Start, instead of commence
      Stop, instead of cease
   Think about, instead of contemplate
   Short, simple sentences - Sentences that are short, making one point only, make content easier to absorb. Long sentences that include a number of clauses become confusing, and may be misunderstood.
   The active, rather than passive voice:
      With the active voice the subject of a sentence takes the action while with passive voice the subject is acted upon. For example:

   **Active**: Maria returned the book to the library.
   **Passive**: The book was returned to the library by Maria.

   Using the active voice makes writing clear, direct and dynamic. It can also help reduce the length of sentences.

Weigh the importance of every idea
What you leave out is just as important as what you include
Every idea you include – from the paragraph to the phrase – should pass the test of two questions:

   **Does the reader need to know this?**
   **If I could say one sentence to my reader, what sentence would I say?**

Before you include any idea in your writing, ask yourself: Do I really need to say this?

Write content that is concise, scannable and objective

Concise

Wordy writing impairs the usability of a site by hiding valuable content within unnecessary text. A common source of unnecessary text includes welcome messages in every module
Tips for writing concise text include:

- Cut all unnecessary words, phrases and sentences
- Use a shorter word over a longer one
- Use the active voice whenever possible
- Print out and edit your text - aim to cut it in half
- Get a colleague to edit it with these aims in mind

**Scannable**

Most users scan a page’s content looking for links, headings and keywords. Tips for improving **scanability** include:

- Use **headings** and subheadings; ensure they **accurately describe the text** below
- Keep **paragraphs short**; stick to one **topic per paragraph** and introduce it in the first sentence
- Use short, simple sentence structures; **one thought per sentence**
- Choose a **shorter word** over a longer one
- Emphasise **key words** or phrases by bolding them (write ‘bold’ after the text you wish to be bolded).
- Use **dot point** lists

**Objective**

Tips for writing objective text include:

- Use and cite evidence to substantiate claims
- Say it as it is, without exaggeration
- Use real-life critical incidents/cases, ensuring confidentiality is maintained

**Referencing**

Acknowledging (citing) what you have read, paraphrased, or ideas you have used from others, avoids plagiarism.

A **direct quote** needs to be referenced as such eg ‘...’ (1)

However, direct quotes should be kept to a minimum.

**Let the Project Manager know if any of the materials, for example tables, diagrams, pictures, cartoons etc require copyright permission to reproduce. Material available on the web, copied into a document often requires permission to reproduce as well – do not assume that because it is in the public domain, that there is automatic permission to reproduce. When asked, most authors will grant, in writing, permission to reproduce.**

When using references/sources, make sure you copy the full reference as you are writing, it is too easy to forget where you got the information when we require it later for acknowledgement.

In this Program we are using the Vancouver style of referencing
Citing using the Vancouver style of referencing

A footnote/endnote style set by the International Committee of Medical Journal Editors (ICMJE)
Number each quote or paraphrase, then give the details of where to find it in a reference list at the end
of the module
Using this system, references are numbered in the order in which they are cited in the text.

For example:
...as one author has put it "the darkest days were still ahead" (1)
...this has been well documented in the literature (2-5).
The author's name can also be integrated into the text. For example: Scholtz (2) has argued
that...

Superscripts will be used in this Program - For example: ...was discovered. (1)

References are listed in numerical order at the end of the paper.
For example:

Referencing a book

Author's surname Author's first name or initial. Title of the Book. Edition [if not first]. Place of
publication: Publisher's name; Year of publication.

Example:

Note: Edition is not needed here, as this is a first edition. The title of the book is not put in italics or
underlined.

Referencing a chapter

Author's surname Author's first name or initial. Title of chapter. In: Editor's surname Editor's's first name
or initial, editor. Title of the book. Edition [if not first]. Place of publication: Publisher's name; Year of
publication. p. page numbers of chapter.

Example:

Referencing a journal

For an article from a journal or magazine: Author's surname Author's first name or initial. Title of article.
Title of the Journal [abbreviated] Year of publication; Volume Number (Issue number): Page numbers of
article.
Example:

To determine appropriate journal title abbreviations, see Journal Abbreviation Sources

Referencing a conference paper

Author's surname Author's first name or initial. Title of paper. In: Editor's surname Editor's first name or initial, editor. Title of the Conference; Date of Conference; Place of publication: Publisher's name; Year of Publication. Page numbers.

Example:

How do I put a webpage citation together?

Web pages can be tricky, because it is hard to find all the information you need.

If you can find the name of an editor or author: Author/editor's surname author/editor's first name or initial. Title of page. Title of site. Last update or copyright date. URL (Access date).

Example:

Note: No use of editor because P. Hudson is credited as the author.

If you can't find the name of an editor or author use this format. Remember, consistency is what really counts: Title of page. Title of site. Last update or copyright date. URL (Access date).

Example:

A Vancouver style reference list

The sources that you refer to in your text should be numbered and then listed in number order.


3. Richardson AJ. Traffic planning and modelling: a twenty year


APPENDIX Q: Letter of invitation to the educational group pharmacists regarding the educational program

Invitation to participate in an online education program: Pharmacists and Palliative Cancer Care

Following the completion of a questionnaire early in 2004, you registered your interest in participating in an online educational program for community pharmacists in palliative cancer care.

After further research, the program: Pharmacists and Palliative Cancer Care has now been developed, and will commence in March 2005, to be completed by end of May 2005.

We are now inviting you to participate in the program and its evaluation. This is an innovative online educational program developed specifically for community pharmacists. A CD of the program will also be posted to you. Some of the program learning can be done online, while much of it can be done by computer, or information can be printed.

The attached Explanatory Statement explains details what is involved in this research project and in completing the program.

If you have any questions concerning this project please contact Safeera Hussainy on 9903 9025, or Jill Beattie at the Victorian College of Pharmacy.

Email: jill.beattie@vcp.monash.edu.au
Telephone: 03 9903 9080
Mobile: 0414 835 408
Fax: 03 9903 9629
APPENDIX R: Explanatory statement for the pharmacists undertaking the educational program

Explanatory Statement: Education Group Pharmacists

Date: January 2005

Project Title: Improving medication management of palliative care patients: Enhancing the role of community pharmacists.

About the Explanatory Statement
This Explanatory Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this Explanatory Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative, friend or colleague. Feel free to do this. Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project. You will be given a copy of the Explanatory Statement and Consent Form to keep as a record.

The Aim of the Research Project
The Pharmacy Guild of Australia is funding research to develop, implement and evaluate an educational program for community pharmacists in palliative cancer care. The major aims of the program are to increase the knowledge and skills of pharmacists in the delivery of effective palliative cancer care, and as a result, improve medication knowledge of palliative cancer care patients. My name is Safeera Hussainy, and I will be doing this research as a PhD candidate under the supervision of Professor Roger Nation, Dr Jennifer Marriott and Mr Michael Dooley who are from the Department of Pharmacy Practice, Victorian College of Pharmacy, Monash University.

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of this Institution.

Palliative care relates to the care of patients who have a progressive life-threatening illness. Approximately 70 to 80% of patients receiving palliative care are at home, and most receive ongoing prescription and over-the-counter medicines from their community pharmacist. Many community pharmacists, however, may not have the knowledge, skills and confidence to contribute effectively to the delivery of palliative care services to people living in the community. If given adequate education and training, community pharmacists are in an ideal position to offer an increased range of services.

Who will be participating in the program
An educational program in palliative cancer care has been developed for community pharmacists. This educational program will be trialled and evaluated by recruiting approximately 30 to 60 community pharmacists from western metropolitan Melbourne, who will be allocated to either a test group (doing the program) or control group (not doing the program). The pharmacists not doing the program will have access to the educational program, after completion of the project.
Why You Are Being Invited to Participate
As a community pharmacist who participated in the project in 2004 by completing a questionnaire, we are now offering you the opportunity to participate in the educational program and its evaluation.

The primary method of delivery of the educational program will by via the web, with paper-based support. Emphasis will be upon problem-based learning that facilitates translation of the factual material into a practice context and builds the confidence of pharmacists in applying their newly acquired knowledge. A ‘discussion’ group will be established at the website to encourage networking among participating pharmacists (to share experiences, problems and solutions) and to provide a mechanism for feedback from palliative care specialists. The discussion group will be monitored and moderated by Peter MacCallum Cancer Institute, Victoria, Australia.

What does participation involve?
Prior to commencing the program, you will be asked to complete a multi-choice, problem-based questionnaire designed to assess your current knowledge in palliative cancer care. Following completion of the program you will be asked to complete another multi-choice, problem-based questionnaire designed to assess your new knowledge in palliative cancer care. This will assist the research team in the evaluation of the educational program. It will take approximately 1 hour to complete this questionnaire.

Participation in the educational program will take place from the beginning of March and complete at the end of May 2005. It is anticipated that completion of the program will take approximately 20 hours over the 12 week period. As it is a flexible program you may do it at any time convenient for you during this period.

On completion of the program, we also request that you complete a program evaluation form. Results from this questionnaire will assist the researchers to make any changes necessary to the educational program based on your feedback.

What to do now
Please contact the research project manager Jill Beattie: email jill.beattie@vcp.monash.edu.au fax 03 9903 9629, telephone 03 9903 9080 or mobile 0414 835 408, to accept or decline participation in the project. Participation is voluntary. Your personal information will be identified by a code number so you remain anonymous.

Your Anonymity
No findings which could identify you as an individual participant will be published. Only the combined results of participants will be published. You may contact the research project team if you would like a copy of the results. Only the researchers will have access to the original data, which will be retained in the Department of Pharmacy Practice for no longer than five years after completion of the project. After this, the data will be disposed of by shredding.

You will not be paid for your participation in this project. For those pharmacists who complete the educational program, either as part of this study, or by accessing it after the study, you may be awarded with continuing pharmacist education (CPE) points.

Questions
If you have any questions or would like to be informed of the research findings, please contact: Jill Beattie on telephone 9903 9080 or mobile 0414 835 408, and Safeera Hussainy on telephone 9903 9025 or 9903 9629 (fax).
Complaints
Should you have any complaint concerning the manner in which this research (Project number: 2003/834MC and R03/48H) is conducted, please do not hesitate to contact the research Committees below.

The Secretary
The Standing Committee on Ethics in Research Involving Humans
PO Box No 3A
Monash University
Victoria 3800
Telephone +61 3 9905 2052
Fax +61 3 9905 1420
E-mail: SCERH@adm.monash.edu.au
Project Number: 2003/834MC

Vicky Karitinos
Secretary of the Research Ethics Committee, Mercy Health and Aged Care
C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: VKaritinos@mercy.com.au
Project Number: R03/48H

Thank you. Safeera Hussainy PhD Scholar.
APPENDIX S: Consent form for the pharmacists undertaking the educational program

MONASH University

Informed Consent Form for Education Group Pharmacists

Project Title: Improving medication management of palliative care patients: Enhancing the role of community pharmacists.

I agree to take part in the above Monash University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that I am willing to:

- Complete a questionnaire to assess my knowledge of palliative cancer care before and immediately after completion of the program.
- Participate in the educational program for the assigned period of time.
- Complete a program evaluation form at the end of the program.
- Allow the researchers to collect and record my personal information.

I understand that any information I provide is confidential, and that no information that could lead to my identification will be disclosed in any reports on the project, or to any other party.

I also understand that my participation is voluntary and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

___________________ (Your signature)  ____________________________ (Your printed name)
___________________ (Date)

Fax the completed consent form to Jill Beattie on 03 9903 9629

If you require further information, or if you have any questions about this project, please contact Jill Beattie on 9903 9080 or 0424 835 408, or Safeera Hussainy on 9903 9025.

Should you have any complaint concerning the manner in which this research (Project number: 2003/834MC and R03/48H) is conducted, please do not hesitate to contact the research Committees below.

The Secretary
The Standing Committee on Ethics in Research Involving Humans
PO Box No 3A
Monash University
Victoria 3800
Telephone +61 3 9905 2052  Fax +61 3 9905 1420
E-mail: SCERH@adm.monash.edu.au

Vicky Karitinos
Secretary of the Research Ethics Committee, Mercy Health and Aged Care
C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: VKaritinos@mercy.com.au

Thank you
APPENDIX T: Letter of welcome and instructions for the pharmacists undertaking the educational program

Jill Beattie  
Program Manager  
Pharmacists and Palliative Cancer Care Program  
Department of Pharmacy Practice  
Victorian College of Pharmacy

Dear

Welcome to the Pharmacists and Palliative Cancer Care Program.

To get started, complete the attached Pre-knowledge Questionnaire and return it in the Reply Paid envelope as soon as possible – prior to the commencement of the program.

The program will commence online, on 7th March 2005, to be completed by 10th June 2005. The Program CD will be sent out to reach you by 14th March 2005. For further information, refer to Attachment A.

As explained in the Explanatory Statement sent to you previously, completing the Pre- and Post-knowledge Questionnaires will assist in the evaluation of the impact of the educational program.

Don’t be put off if you find you cannot answer various questions – the aim of the Program is to increase your knowledge in palliative cancer care.

Your user ID, which has been randomly allocated by us, can be found on the front of the Pre-knowledge Questionnaire, and is:

You will also need this number to enter the web site - refer to Attachment A.

Attachment A provides further information to get you going on the web site. Attachment B provides some communication points for collaborating online – e.g. in the Discussion Groups.

Further information will be available to you online, within the Program. Put a date in your diary now, to log on to the Program on 7th March 2005, and begin, by allocating about an hour to find your way around the material.

We wish you well and hope you enjoy the Program!

The Pharmacists and Palliative Cancer Care team.
Attachment A: Let’s get going!

These directions can be followed from 7th March 2005.

Contents of Appendix A

1. Getting into the Pharmacists and Palliative Cancer Care web site

Flexibility

A) From Module 1 through to Module 11
B) From the Key Messages
C) From Case Study to Case Study
D) From Activity to Activity

2. The Accompanying CD

What can you do from where?

1. Getting into the Pharmacists and Palliative Cancer Care web site

Once you have logged on to the Internet, type the Internet address for the Program: http://www.pallpharmacists.com

When the Pharmacists and Palliative Cancer Care web site is visible, enter your username - this is the user ID given to you in the attached letter, and on the front page of your Pre-knowledge Questionnaire.

If you are not familiar with working online, read the Welcome to Pharmacists and Palliative Cancer Care web site information and follow from one set of directions to another.

If you are familiar with working online, it is advisable to still read the Welcome to Pharmacists and Palliative Cancer Care web site information. However, you may also wish to click on the Start here option on the main menu bar to get going.

When you click on the Module option on the main menu bar, it is still advisable to read the information about Navigating the Modules to make getting around the site more efficient.

Flexibility

We all learn differently, and research has shown that not everyone learns in a linear fashion – so there are a number of different ways of using the resources and learning the material in this Program.

A) From Module 1 through to Module 11

You might want to start with Module 1 and work through to Module 11.

The Navigating the Modules option shows you how to do this.
Appendix T

B) From the Key Messages

When you click on the Modules option on the main menu bar, you will also see a list of Modules on the left-hand side of the screen, however there will also be an option called Overview of the Modules.

When you click on the Overview of the Modules option, you will see a list of the Key Messages for each module in the table. You can use the Key Messages as a guide to the order in which you choose to cover the material.

You will also get an idea of how much time to allocate to each module – e.g. Module 3: Management of cancer pain is estimated to take about 4 hours, while most of the other modules are about 1 hour (except for Module 4 – which is 6 hours).

Whichever module you choose to start with, it is still advisable to start with Module 1: Getting the most from the Program.

The Key Messages will give you an idea of which module you might like to continue with next – depending on your previous knowledge, experience, interest and learning needs (according to your client base).

C) From Case Study to Case Study

When you click on the Modules option on the main menu bar, you will also see a list of Case Studies on the left-hand side of the screen.

When you click on the Case Studies option, another list will also appear in the right hand pane - with the title of the Case Study. The title of each of the Case Studies will give you an idea of the learning opportunities they provide.

You can then click on the Case Studies in the right-hand pane and cover them according to your previous knowledge, experience, interest and learning needs (according to your client base).

Whichever way you choose to start, it is still advisable to start with Module 1: Getting the most from the Program.

D) From Activity to Activity

When you click on the Modules option on the main menu bar, you will also see a list of Activities on the left-hand side of the screen.

When you click on the Activities option, another list will also appear in the right hand pane - with the title of the Activity. The title of each of the Activity will give you an idea of the learning opportunities they provide.

You can then click on the Activities in the right-hand pane you can cover them according to your previous knowledge, experience, interest and learning needs (according to your client base).

Whichever way you choose to start, it is still advisable to start with Module 1: Getting the most from the Program.
2. The Accompanying CD

The aim of also providing a CD option from which to work through the Program, is to reduce your time on the Internet.

Remember you will need to access the Internet on 7th March 2005, to commence the Program, familiarise yourself with how it works, and commence working with the material.

Approximately a week later, you will receive the CD by post.

What can you do from where?

<table>
<thead>
<tr>
<th>What can you do?</th>
<th>From where?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internet/Online</td>
</tr>
<tr>
<td>Read the Program material</td>
<td>☺</td>
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<tr>
<td>Print sections</td>
<td>☺</td>
</tr>
<tr>
<td>View the Activities</td>
<td>☺</td>
</tr>
<tr>
<td>Use the spaces provided with some Activities, to write text</td>
<td>☺</td>
</tr>
<tr>
<td>Follow internet links to other sites</td>
<td>☺</td>
</tr>
<tr>
<td>Follow links to material on the CD</td>
<td>☺</td>
</tr>
<tr>
<td>Submit responses to specified Activities to the Notice Board</td>
<td>☺</td>
</tr>
<tr>
<td>Post to / join / interact with, the Discussion Group</td>
<td>☺</td>
</tr>
<tr>
<td>Communicate technical issues to the web designer</td>
<td>☺</td>
</tr>
<tr>
<td>Communicate / give feedback, to the Project Manager</td>
<td>☺</td>
</tr>
</tbody>
</table>

☺ = can do

☺ = facility not available
Attachment B: Communication points for online collaboration

Contents of Appendix B

Collaboration and networking online

Format
Brevity
Clarity
Quoting
Avoid ‘Me-tooing’
Etiquette

Collaboration and networking online

- The Discussion Group option has been provided to enable you to communicate with one another and other palliative care experts.
- Activities and Case Studies throughout the program are designed to stimulate discussion which can be continued through participation in the Discussion Group.
- More information about the Discussion Group can be found in Module 1: Getting the most from the Program, and also by clicking on the Discussion Group option on the main menu bar.
- Interacting with discussions is voluntary, and often referred to as ‘Posting’ to the Discussion Group – or ‘Joining’ the Discussion Group.

It is therefore important to cover some basics about writing on-line, so you can:
- Be properly understood
- Get your points across effectively
- Avoid annoying other participants

Format
- DON’T WRITE EVERYTHING IN UPPERCASE!
- Mixed-case text is more relaxing to read.
- Uppercase is sometimes used, when somebody wants to indicate that they are SHOUTING! But few people will read a message that SCREAMS at them.
- Keep sentences/ phrases short
- Leave a space between paragraphs.
- People often skip large blocks of text.
- For further information on formatting you may wish use - click on Discussion Groups on the main menu bar, then click on Go to the Discussion Group, then in the top right-hand corner, click on FAQ (Frequently Asked Questions) – then refer to the FAQ Table of Contents.

Brevity
- Be concise - get to the point.

Clarity
- Check what you have written before you send it
- Reading it out loud will be a good check for clarity
- Avoid using acronyms.
- Use common abbreviations, acronyms and symbols sparingly. If you are going to use an abbreviation often that may not have a common understanding, define it the first time you use it. Also, while some acronyms (such as BTW, which means ‘by the way’) are well known, you can’t be sure that all of your readers know what they mean.
Quoting

- If you are replying to a specific point or question raised in a message it is preferable that you do ‘quote’ that message/part of the message, to give context to your reply.
- You should only include enough of the original message to put your reply into context - edit out all the irrelevant material to keep your message brief.
- Avoid ‘step-laddering’. Sometimes people quote entire messages that contain quotes from earlier messages, which in turn contains quotes from still earlier messages. Messages that contain ‘quotes in quotes in quotes’ are said to be step-laddering.
  - By the time the reader gets to your text, it is not clear what you are commenting on.
  - Once again, you should extract only a few sentences that accurately represent the topic you are writing about.
- When appropriate, alternate between quotes and your comments. Sometimes it is not possible to find a few sentences in the original message that clearly convey what the writer was talking about. Here is an example of selective quoting. The lines that start with the > symbol indicate text taken from the original message:

> So I said to him that Mac is better than Windows
There is a comparison report in this month’s issue of “Computer World”. It shows that each platform has unique advantages.
> The Mac interface was invented by Apple Computer
Did you know that the Mac interface was based on a design from the Xerox PARC center?
> Still, Mac’s are better than PC’s any day.
That really depends on what your application is, don’t you think?

In the example above, each comment is directly targeted at a specific comment made by the other person. Don’t force your readers to guess at what part of the original message you are talking about.

Avoid ‘Me-tooing’

- Some people quote a huge message, then place a brief comment at the end, such as “I agree with this” or “Me too!”
- This can be annoying to the person who has to scroll all the way through the message, looking for the part that you wrote.
- Quote only a few important sentences that summarise the message adequately, and place your comment after that.
- Simply saying that you agree with something doesn’t add much to the conversation/collaboration/learning experience.
- Tell people why you agree? You can state some of the reasons that you feel the way you do.

Etiquette

- There are many ways to get people ‘net-annoyed’ with you.
- The worst problem is something called ‘keyboard bravery’. When you are sitting comfortably in front of your computer, safe from the world, it is often tempting to write a message that is so harshly phrased that it is insulting.
- You should always read what you have written before you send your message. Reading it out loud is even better.
- Not only will this help the readability of your contribution, but you may also notice that you don’t sound as friendly as you would like.
- A good rule of thumb is to be conservative in what you send and liberal in what you receive. That is, you should not send heated messages (called ‘flames’) even if you are provoked. On the other hand, you shouldn’t be surprised if you get ‘flamed’ and it’s prudent not to respond to flames.
- Remember that the recipients of your messages are human beings whose culture, language and humour have different points of reference from your own.
- Use ‘smilies’ to indicate tone of voice.
- You will find how to use smilies etc by clicking on Discussion Groups on the main menu bar, then click on Go to the Discussion Group, then in the top right-hand corner, click on FAQ (Frequently Asked Questions) – then in the FAQ Table of Contents – go to How can I use smilies and images.
Appendix U: Pre-knowledge questionnaire

Pharmacists and Palliative Cancer Care
Online Educational Program
Pre-Knowledge Questionnaire

PLEASE FIND YOUR PROGRAM ID NUMBER BELOW

This is the ID number that you will use in the Program.
It will also be used to compare the results of your pre-knowledge questionnaire
with your post-knowledge questionnaire results

ID Number:

Date:

As part of the evaluation of the study, pharmacists are required to complete a pre- and a post-knowledge questionnaire.

Prior to commencing the study, complete this pre-knowledge questionnaire. You may look up resources if you wish. It is anticipated that the questionnaire will take 30-45 minutes to complete.

Please return immediately – or, no later than 16th March 2005 - by post in the Reply Paid envelope provided.

If you have any questions, please contact Jill Beattie on: 0414 835 408

N.B. Results of this questionnaire and the answers will be provided at the end of the Program, along with the results of the post-knowledge questionnaire.

_____________________________

INSTRUCTIONS

The questionnaire contains 20 questions, with a mix of multiple-choice and short-answer questions.

Select the single best answer for multiple choice questions.
QUESTIONS

1. The most important additional therapy to consider when starting a patient on opioids for pain is:

   a) Amphetamines to increase alertness
   b) Antidepressants as an adjuvant for pain relief
   c) Laxatives to prevent constipation
   d) Non-steroidals (NSAIDs) to treat inflammation

2. Neuropathic pain is often characterised by a:

   a) Dull achy pain
   b) Colicky pain
   c) Low-grade gnawing pain
   d) Electric shock-like pain

3. A patient is taking an oxycodone immediate release tablet 5 mg (Endone), 4 times a day. What is the equivalent dose of a long-acting morphine preparation?

   a. 15 mg q12h
   b. 15 mg q8h
   c. 30 mg q12h
   d. 30 mg q8h

4. Mrs BZ is a 72 year old woman with end-stage cancer of the breast. She is at home, and has severe pain. Currently she is receiving MS Contin 60 mg q12h and prn oral hydromorphone. The community palliative care nurse calls in to pick up the patient’s medicines and tells you that she feels Mrs BZ needs parenteral opioids. She is unable to swallow medicines and has no intravenous access. Which of the following is the most appropriate route to recommend for opioid analgesic administration?

   a) Intramuscular
   b) Subcutaneous
   c) Intravenous via a PICC line catheter
   d) Intravenous via a peripheral intravenous catheter

5. Mr LV is a 67 year old man with prostate cancer. He has severe pain over his left hip and has been receiving the same dose of opioids for more than six months. During the last two weeks, the pain has worsened and increasing doses of opioid analgesics have been given. The pain is constant, aching and localised, without any referred pain. Increasing pain in Mr LV most likely represents:

   a) Worsening metastatic cancer
   b) Opioid addiction
   c) Opioid tolerance
   d) Opioid dependence
6. Mrs KO is a 45 year old woman who has metastatic carcinoma of the breast, with bone, lung and liver secondaries. Her husband comes into the pharmacy to fill a prescription for morphine. He tells you that he is extremely concerned because Mrs KO is very nauseous. He asks you for something for the nausea. Before you can advise Mr KO, list 4 questions you would ask Mr KO in determining the best option for his wife’s nausea.

7. Mrs SC has just been prescribed morphine (controlled-release oral preparation) for the first time for cancer-associated pain. Which of the following would be the most appropriate approach to the management of possible opioid-induced constipation:

   a. If constipation occurs after commencing morphine, introduce a fibre-based laxative
   b. Commence a stimulant laxative such as senna at the same time as the morphine
   c. If constipation occurs after commencing morphine, introduce a stimulant laxative such as senna
   d. Commence a stool softening agent combined with a bowel stimulant at the same time as the morphine

8. Miss BT, who has advanced cancer, has been having increasing difficulty with a dry mouth. Which of the following is the least appropriate advice for management of this symptom?

   a. Regular rinsing with an antiseptic gargle
   b. Taking of frequent sips of water and/or sucking on ice chips
   c. Regular rinsing with water or normal saline
   d. Using chewing gum

9. Intermittent bouts of sudden diarrhoea following constipation, with little warning of defecation, is most likely to be caused by which one of the following?

   a. Too much stimulant laxative
   b. Faecal impaction
   c. Too much stool softening laxative
   d. A malabsorption syndrome
10. Mr AS has recurring carcinoma of the tongue, which has spread to his lower jaw, despite chemotherapy and radiotherapy. His prognosis is poor, and treatment is now aimed at symptom management only. Mrs AS comes into your pharmacy very worried about Mr AS’s weight loss. He is that weak that she needs to “do everything for him” he sleeps most of the day and won’t eat or drink. Mrs AS says “Do you think I should keep pushing him to eat?”

Which of the following would you advise?

a. Patients with cancer lose weight because they don’t get enough nutrition, yes, you should keep at him to take more
b. Not eating or drinking in cancer is caused by nausea and constipation, when we fix those he will eat more
c. This type of weight loss in cancer is related to local effects of the tumour and increased metabolic demands, therefore give him what he will tolerate
d. It is important to keep a record of what he eats and drinks so that the doctor can decide what best to feed him, so monitor him carefully

11. Three months after a patient’s death her husband comes to your pharmacy for something to help him sleep. He tells you that he sometimes thinks his wife is in the house talking to him, that he imagines he hears her voice, he has gained 10.5 kg since her death, but otherwise feels well. He says he thinks he is ‘going mad’, and asks you whether you think he should go to a psychiatrist. These symptoms are most consistent with a:

a) Complicated grief reaction
b) Major depression
c) Normal grief reaction
d) Post-traumatic stress disorder

12. Death from the side effects of using opioid analgesics, used with the intent to treat severe dyspnoea in a dying patient, is an example of:

a) Unprofessional practice
b) Double effect
c) Euthanasia
d) Physician-assisted suicide

13. Off-label medicines are:

a. Also known as ‘orphan’ drugs
b. Used outside the TGA approved indications
c. Illegal for pharmacists to dispense
d. Rarely used in palliative care and cancer treatment
14. Mrs UL comes into your pharmacy to fill a prescription for her husband for prednisolone, augmentin, naproxen, cyclosporine and morphine. Mr UL is 54 years old and has been diagnosed with inoperable and incurable lung cancer. Mrs UL tells you that the GP thinks Mr UL shows some signs of depression, but not enough to diagnose a formal major depression - the GP thinks that Mr UL’s change in mood could be due to depression, medications (e.g. steroids and chemotherapy) and/or cerebral metastases. Mr UL does not want to take any more pharmaceutical medicines but is open to looking at complementary and alternative medicine (CAM) treatments. Mrs UL says that she has read that St John’s Wort is good for depression.

What do you advise about the suitability of St John’s Wort for Mr UL?

a. St John’s Wort is safe and can be used for Mr UL  
b. St John’s Wort can be commenced to see how Mr UL responds to it  
c. St John’s Wort interacts with numerous other medicines and is relatively contraindicated for Mr UL  
d. St John’s Wort has been proven to be more effective than other antidepressants

15. When a palliative care patient or their carer tells you that they are taking herbal medicines, which of the following questions is the least important to ask?

a) What medicines are they taking?  
b) How much do they cost?  
c) What are they taking the medicines for?  
d) Are they allergic to any plant products?

16. Suffering encompasses more than physical pain. List 3 other areas that may cause suffering in the patient receiving palliative cancer care.

17. Surveys indicate that less than 50% of palliative care patients with cancer receive adequate pain relief. A number of barriers to the provision of effective pain relief have been found to be related to healthcare professionals - list 3 such barriers.
18. It is often very difficult to communicate effectively with palliative care patients or their carers when they come to your pharmacy to fill prescriptions. Which of the following is the least the important consideration if you are to communicate effectively with these customers when they come into your pharmacy?

   a) Allocation of a hour time-slot
   b) A quiet place to sit
   c) A welcoming smile
   d) A show of empathy

19. When reviewing medicines of palliative care patients, there are a number of known factors that predispose the patient to medication-related adverse events. List 4 risks factors that predispose patients to medication-related adverse events.

   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

20. Spinal cord compression secondary to metastatic disease is potentially devastating. It can result in paraplegia; however, early signs may be detected. List 3 signs and symptoms that may alert you to a patient presenting with impending spinal cord compression.

   ........................................................................................................................................
   ........................................................................................................................................
   ........................................................................................................................................

Thank you
Please return your questionnaire in the Reply Paid envelope provided.
If the envelope has been mislaid, please forward to:

Safeera Hussainy
Victorian College of Pharmacy
Department of Pharmacy Practice
381 Royal Parade
Parkville, Victoria, 3052
Appendix V: CD-ROM instructions, suggested timelines and credit points for completion of the program

Pharmacists and Palliative Cancer Care

Find attached:

1. Guidelines for using the CD-ROM
2. What you can access from where
3. Suggested timelines for completing the Program
4. Allocated CPE Points for completion of various Modules of the Program

Please note, that not all functions are available from the CD.

Using the CD-ROM based version of the website.

Insert the ‘Pharmacists and Palliative Cancer Care’ disk into the CD-ROM drive of your computer. Using windows explorer - locate the CD-ROM drive and highlight. On the right hand side pane you will see the contents of the CD_ROM (see figure 1).

![Image of CD-ROM contents]

Figure 1. Contents of the Pharmacists and Palliative Cancer Care CD.
Double click on the default.htm file located on the CD. The Website will then be displayed in your Internet explorer.

Please note that while this is an exact copy of the live website (www.pallpharmacists.com) some of the functionality is not possible. In particular the use of the ‘Notice Board’ and the ‘Discussion Groups’. You will need to log on to access these.

**What can you do from where?**

<table>
<thead>
<tr>
<th>What can you do?</th>
<th>From where?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read the Program material</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Print sections</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>View the Activities</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Use the spaces provided with some Activities, to write text</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Follow Internet links to other sites</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Follow links to material on the CD</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Submit responses to Activities to the Notice Board</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Post to / join / interact with, the Discussion Group</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Communicate technical issues to the web designer</td>
<td>☑ ☑</td>
</tr>
<tr>
<td>Communicate / give feedback, to the Project Manager</td>
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</table>

☑ = can do ☐ = facility not available

**Suggested Timelines**

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Dates</th>
<th>Modules</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16th - 23rd March</td>
<td>1, 2 (1 hour each)</td>
</tr>
<tr>
<td>2</td>
<td>24th - 30th March</td>
<td>3 (4 hours in total)</td>
</tr>
<tr>
<td>3</td>
<td>31st March - 6th April</td>
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<tr>
<td>4</td>
<td>7th - 13th April</td>
<td>4 (6 hours in total)</td>
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<tr>
<td>5</td>
<td>14th - 20th April</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>21st - 27th April</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>28th April - 4th May</td>
<td>5 (1½-hours)</td>
</tr>
<tr>
<td>8</td>
<td>5th - 11th May</td>
<td>6 (1 hour)</td>
</tr>
<tr>
<td>9</td>
<td>12th - 18th May</td>
<td>7, 8 (1 hour each)</td>
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<tr>
<td>10</td>
<td>19th - 25th May</td>
<td>9 (1 hour)</td>
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<tr>
<td>11</td>
<td>26th May - 1st June</td>
<td>10 (1 hour)</td>
</tr>
<tr>
<td>12</td>
<td>2nd - 8th June</td>
<td>11 (1 hour)</td>
</tr>
<tr>
<td>Post-Knowledge questionnaire</td>
<td>Complete &amp; return by 15th June</td>
<td></td>
</tr>
</tbody>
</table>

**CPE Points**

Following completion of the program – by 15th June 2005 - PSA requires us to send them a list of participants, including membership number, name and postal address, together with a list of the modules completed by the pharmacist. Therefore, it is important that you provide us with documented evidence that you have completed each of the Modules.

We will send you further information and seek your consent to do this – via email – at a later date.

As you are aware, this Program is part of a larger research project, which also has strict timelines for completion. Therefore, you will understand that an extension of timelines for completion of the Program will not be available at this time.

PSA has recognised this Program under their CPD & PI Program, according the PSA Guidelines, credit points will depend on modules completed and are as follows:

- For all one-hour modules = 2 credit points
- For module 3 = 9pts
- Module 4 = 12pts
- Module 5 = 3pts

We look forward to working with you!
Appendix W: Pharmacists and Palliative Care Program - Evidence for completion of the modules

<table>
<thead>
<tr>
<th>Date comm</th>
<th>Date compl</th>
<th>Module</th>
<th>Hours</th>
<th>Activities completed</th>
<th>Comments</th>
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<tr>
<td>Example: 17 March</td>
<td>Example: 19 March</td>
<td>1 - Getting the most from the program</td>
<td>1½ hrs</td>
<td>Example: 1.A: Yes 1.B: No 1.C: Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 - Getting the most from the program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 - Introduction: Principles of palliative cancer care</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3 - Management of cancer pain</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>4 - Management of on-pain symptoms and side effects of treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 - Complementary and alternative medicines used by patients with cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 - Methods of medication administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 - Access to palliative cancer care medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 - Psychosocial care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 - Communication with patients, carers and families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 - Ethical issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 - Working in partnerships to enhance patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NAME:  Print clearly ____________________________  Signature ____________________________

POSTAL ADDRESS: ______________________________________________________________

PSA MEMBERSHIP NUMBER: ____________________________  DATE: ____________________________
Appendix X: Moderator’s Guidelines

Pharmacists and Palliative Cancer Care Educational Program

Online Discussion Group

Moderator’s Guidelines

4th March 2005
Prepared by:

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Care & Werribee Mercy Hospital

Mr Bill Scott, National Vice President & Victorian Branch President The Pharmacy Guild of Australia

Acknowledgements:

We would like to thank Mr Rohan Elliott and his team from the Department of Pharmacy Practice,
Victorian College of Pharmacy, Monash University, for allowing us to use, as a source of information, the
Moderator’s Manual (January 2004, version 1) for the Pharmacy Pre-registration Training Program.
Contents

MODERATOR'S GUIDELINES............................................................................................................. 116
CONTENTS ...................................................................................................................................... 118
1. PURPOSE ..................................................................................................................................... 119
2. AIMS .......................................................................................................................................... 119
3. ROLE OF THE MODERATOR ....................................................................................................... 119
   WHAT IS THE EXPECTED TIME INPUT? .................................................................................... 120
4. ACCESSING AND USING THE DISCUSSION GROUP .............................................................. 120
5. KEY POINTS FOR MODERATING DISCUSSION GROUPS ........................................................ 120
6. WHAT IS EXPECTED OF PARTICIPANTS? ................................................................................ 124
7. PROGRAM ADMINISTRATION, SUPPORT AND FEEDBACK .................................................. 125
   RECORDING THE PROCESS ....................................................................................................... 125
   SUPPORT ................................................................................................................................... 125
REFERENCES .................................................................................................................................... 125
APPENDIX 1: USING THE DISCUSSION GROUP .......................................................................... 127
APPENDIX 2: GUIDELINES FOR E-COMMUNICATION FOR THE MODERATOR ....................... 127
APPENDIX 3: INFORMATION SENT TO PARTICIPANTS IN HARD COPY PRIOR TO
   COMMENCING THE PROGRAM .................................................................................................. ERROR! BOOKMARK NOT DEFINED.
ATTACHMENT A: LET'S GET GOING! ............................................................................................ ERROR! BOOKMARK NOT DEFINED.
ATTACHMENT B: COMMUNICATION POINTS FOR ONLINE COLLABORATION ............................ERROR!
   BOOKMARK NOT DEFINED.
APPENDIX 4: MANAGING POSTINGS ............................................................................................ 127
1. Purpose

A core element of the Monash University, Department of Pharmacy Practice Pharmacists and Palliative Cancer Care Program is the moderated online Discussion Group.

The Discussion Group provides an opportunity for participants to contribute to, and participate in discussion at a time most convenient for them throughout the program. All participants have an equal voice and equal access to the discussion regardless of geographical location.

The Discussion Group consists of around 100 community pharmacists from throughout Australia and is moderated by an experienced palliative care pharmacist who co-opts palliative care physicians, nurses and other palliative care specialists when the need arises. Within the program, there are activities which stimulate discussion and debate and encourage the participants to contribute to the Discussion Group. At other times participants may wish to join the Discussion Group as issues arise.

Published research (Barb et al., 2001; Barbera, 2004; Roberts, 2002) shows that online discussion:
- is a powerful and flexible tool
- allows consultation and collaboration between colleagues and specialists that results in improved educational outcomes
- promotes critical thinking, reflection and analysis of practice
- provides a valuable way to explore clinical and professional issues
- provides an opportunity for networking

2. Aims

Activities and case studies throughout the program are designed to stimulate discussion which can be continued through participation in the Discussion Group.

The Discussion Group has been designed to:
- encourage collaboration, consultation and networking
- address professional practice issues
- assist in the development of problem solving skills
- provide insight into issues related to palliative cancer care that competent practitioners need to understand and address in their day-to-day practice of pharmacy e.g. therapeutic, legal, ethical, professional and workplace issues.

3. Role of the moderator

The moderator’s role is to:
1. Start discussion topics by contributing the initial information/question(s) to the group.
2. Monitor the discussion regularly to ensure that it progresses, stays on track and that any new issues arising are explored further.
3. Contribute to the discussion as required eg:
   a. provide feedback to participants
   b. correct errors or misinformation
   c. provide guidance
   d. add a professional opinion or example from experience
   e. seek the assistance of other pharmacists, physicians, nurses, chaplains, dieticians etc with expertise in the areas/topics being raised
4. Ensure all relevant pharmacy practice issues are identified and discussed.
5. Modify or delete inappropriate contributions. (Refer Appendix 4)
6. Encourage all participants to contribute.

*Roles 1 and 5 are about facilitating the flow of information and ensuring that only correct/appropriate information is communicated.*
You will most commonly be the person to start a discussion thread, however, participants may also do this.

As a guide, refer to some of the Activities within the modules. Some of these actually direct the participants to the Discussion Group.

Messages that you feel are not appropriate can be modified or deleted. For example, a message that is rude, offensive or inflammatory; a message that breaches patients’ or business’ confidentiality, or a message that you feel could be easily misinterpreted. For more information on deleting and modifying postings, refer to Appendix 4.

**Roles 2, 3 and 4 are about being an educational facilitator/mentor.**

A facilitator needs to be guiding, supportive, and on occasions directive, rather than a ‘controller’. The moderator is expected to have less influence in directing participants to a specific analysis and/or conclusion of the material, but rather, is required to provide feedback to participants as needed.

**Role 6 is about creating a safe environment for participants.**

A safe environment needs to be provided, for participants to:

- express themselves freely in appropriate ways
- to share their ideas
- ask questions
- to raise new issues.

If participants feel safe in a positive and motivating environment, they are more likely to contribute to the Discussion Group.

**What is the expected time input?**

Moderating online discussion may be more time consuming than face-to-face teaching because of the amount of information that may be generated as a result of the multiple threads that are taking place in parallel with one another.

It is anticipated that the moderator will need to devote, on average, approximately two hours per week to the Discussion Group. This will involve checking in on the discussion, and if necessary making a contribution, at least four times a week (every 1-2 days). Each time the moderator ‘logs on’ to the Group it might take somewhere between 5 and 20 minutes, depending on how many contributions have been made and whether or not the moderator needs to add a contribution. The moderator should recognise the value of spending time with depth, rather than breadth.

**4. Accessing and using the Discussion Group**

Once you have entered the web site, click on *Discussion Group* in the main menu, then *Using the Discussion Group* – and follow the directions.

This has been reproduced in Appendix 1.

**5. Key points for moderating Discussion Groups**

**Log on regularly**

For the discussions to function effectively, the moderator needs to be in close contact with the Group. Participants get frustrated if questions go unanswered for several days, and they may also get the impression that the moderator is not assisting or addressing the issues as they arise. Your engagement with the Discussion Group needs to be sustained over time, so that participants do not feel isolated, anxious or confused.
You should check in on the discussion every day, but no longer than every second day (about 4-5 times per week) although this will vary depending on what stage the discussions are up to and how well the Group is functioning.

**Provide warning and/or make alternative arrangements if you won’t be able to log on for a few days**

If for any reason you are unable to check in on the Group for a few days (e.g. due to illness or some other unexpected situation) contact the Project Manager, Jill Beattie, on 0414 835 408 so that an alternative moderator can be arranged for this period of time.

**Providing a structure for online discussion**

Participation in the Discussion Groups in voluntary, however, some structure may assist participants.

The moderator can create a structure for online discussion. For example, you might specify:
- The number of issues/questions the participants might like to raise e.g. “Identify two important issues raised by the writer in the text, summarise and post these issues to the Discussion Group.”
- The type of contribution that could be made e.g. “Identify a specific question that is unresolved in your mind and post that question to the Discussion Group.”
- A sequence or interaction pattern e.g. “Select two questions posted in the previous phase by participants and formulate options/answers to those questions and post these answers to the Discussion Group”.
- NB: The length of the contribution will be limited by the web design.

**Contribute to the discussion, but be aware of timing issues**

It is important for the moderator to contribute to the discussion from time to time and provide feedback when appropriate.

Research into the use of online discussions (Ganza, 2001; Jegede, 2001) has found that participant satisfaction is enhanced by instructor (moderator) interaction. If the moderator does not contribute to the discussion and provide feedback, participants perceive the instructor to be ‘absent’, and their satisfaction declines.

However, it is best not to always respond to participants’ messages or correct misinformation too quickly. To facilitate discussion among pharmacists, allow time for them to respond first, unless you feel it is urgent to comment or correct some misinformation.

Encourage the group to collaborate, work together to solve problems and provide answers, and learn from each other.

To promote ongoing discussion and critical thinking, you might also consider asking questions, for example:
- Is the comment etc. based on evidence or experience?
- Give a rationale for your agreements and disagreements with the points/comments raised.
- Can you clarify that point further?
- What alternatives are there to...........

As well as providing feedback and asking questions:
- Feel free to add your opinion, based on experience and evidence
- State how you might handle this situation or how you have handled similar situations.

The Group will benefit from the input of an experienced practitioner such as yourself.

**Be aware of potential for miscommunication**

Communicating electronically can result in messages being misinterpreted. For example, because of the absence of non-verbal communication (body language, eye contact etc.), a message that is not intended to create offence may do so. Using an appropriate ‘tone of voice’ in messages is important.

It is easy for some forms of humour to be misinterpreted when facial expressions are unseen. Sarcasm for example, in any form, is inappropriate.
The use of ‘emoticons’ (keyboard characters representing emotions) may be helpful. For examples using : ) to represent a smiley face can be useful to signify that your message is meant in good spirits if you think it could be misinterpreted as criticism. Refer to Appendix 1.

For more tips on communicating online, see Appendix 2 - *Key points for e-communication*.

**Consider different ways that discussions can be applied in the online environment**

**Informal debate**
- Present a contentious issue and invite responses (with some explicitation of the reasons). Use the program material as a guide.
- The pros and cons of a particular issue could be first argued by several people (participants and/or experts), then a poll of participants could be taken to see which side they support, with general discussion taking place afterward e.g. “Concerning the issue of sedation in the terminal phase, let’s each identify one argument in favour of sedation and one argument against it”.

**Identify the relevant facts**
Ask participants to identify the relevant facts on some issue related to the course. This could be primarily a cumulative process rather than one of debate e.g. “What are the psychosocial issues that palliative care patients and their families confront? Try to identify as many issues as possible, based on your readings and your own insights”.

**Compare and contrast**
In this type of discussion, participants compare and contrast alternatives or different examples of some topic that is under study e.g. “The course presents three detailed case studies of the symptoms that palliative care patients experience. Let’s compare and contrast the symptoms featured in these three case studies. What are the similarities and differences between the three patients and the management strategies used to control their symptoms”?

**Present and discuss examples**
In this type of discussion, participants each present an example, which is followed by a discussion. The discussion may be led by the participant or by the moderator e.g. “Present a report of the palliative care services provided by your pharmacy. Then as a group, let's discuss how each example relates to the topics covered in the course”.

**Potential/difficult problems and their solutions**
Emphasise that the specific problem solution is less important than the feasibility, logic and credibility of the solution, and how well-supported the solution is by valid examples or the supporting evidence e.g. “The case study profiles a family who does not wish for the patient to have injectable Morphine in the home in the case of an emergency. Is this a potential problem? What can you do to help? What would you recommend to the family? Provide an in-depth justification for each strategy that you propose”. Participants can then provide feedback to each other concerning the pros and cons of a problem solution that has been put forward.

**SWOT analysis (strengths, weaknesses, opportunities and threats)**
In this type of discussion, participants each present a report on the strengths, weaknesses, opportunities and threats related to a policy, strategy etc. related to the course subject matter e.g. “The case study profiles a pharmacy that is trying to strategise how to expand its palliative care services. What are the strengths, weaknesses, opportunities and threats that this pharmacy faces as it seeks a strategy for expanding its market”?

**Report on an event**
In this type of discussion, participants comment on an event/situation. This may include a virtual ‘field trip’ to explore a web site which features a topic related to the subject matter of the course. E.g. “Go to a web site on the complementary and alternative medicines used successfully by patients with cancer, and compare this anecdotal information on the medicines to that provided in the course (for levels of evidence etc.) OR “Comment on the issues (therapeutic, legal etc.) that you dealt with when doing a MMR for a palliative care patient in their home”.

122
Role-playing
Take the role of a palliative care patient/carer e.g. “The case study profiles a young, newly diagnosed patient with cancer who wishes to die at home. Let’s take the roles of the patient, carer, family and to discuss the issues that each person faces”.

Be positive and encouraging when responding to messages and/or correcting errors/misinformation
As mentioned above, it is easy for messages to be misinterpreted as criticism. Hence it is important to use a positive message/encouraging tone when responding to participants, even if what they posted was not correct.

Providing communication guidelines
For participants
Although pharmacists in this study may have prior experience with using Auspharmlist®, an interactive forum for pharmacists in Australia, and hence may already be familiar with how to contribute in Discussion Groups, engaging actively in this learning experience could be a daunting, perhaps even prohibitive, prospect for some of them.

Participants have been provided with some simple communication guidelines to deter the amount of frustration in discussion environments – refer to Appendix 3.

Providing communication guidelines helps to solidify the community more fully, since each participant knows the general format and expected process for communication.

For the moderator
Refer to Appendix 2 and 3

Modify/Delete inappropriate messages posted by participants
Messages that you feel are not appropriate should be modified or deleted. For example, a message that is rude, offensive or inflammatory, a message that breaches a patients’ or business’ confidentiality, or a message that you feel could be easily misinterpreted.

If you decide to delete a message you should email the person who sent it to explain why you have done so, perhaps offering them the chance to re-word and re-send it if appropriate. For further information see Appendix 4.

Employ methods to prevent some participants from dominating discussions whilst others do not contribute
If there are one or more participants dominating the discussion (e.g. by always getting in first), try and encourage other participants to contribute sooner.

For example, you could send a message to the whole group to try to get others to respond faster e.g. “We haven’t heard from a number of you – get in quick with your comments and start the ball rolling”.

If there are one or more participants who are not contributing, or contributing infrequently, try and encourage them e.g. “We haven’t heard from a number of you, what do others think about this issue?”

However, do not identify or ‘name’ them.

NB – postings are anonymous – other than the ‘identity’ the participants have given themselves.

‘Sum up’ the discussion topic
When the discussion topic seems to be drawing to an end (at the moderator’s discretion), it is beneficial to ‘sum up’ the issues or problems identified and/or any decisions made. It is most likely that as the moderator in this program, that you will do this.
Ask “What if………” questions
Feel free to add ‘what if…’ scenarios to activities/cases. For example- What if the patient was pregnant? What if the patient was diabetic? What if the doctor was unavailable? This can introduce complexities to the activities/cases and make the participants think more broadly about some issues. It can also be used to extend an activity/case if it looks like it is progressing faster than expected.

Encourage participants to think about the most appropriate information sources
Encourage pharmacists to specify their sources when they make contributions (where appropriate), and to critically evaluate the sources. Ask, “Where did you find the information?” and/or “What resources did you find most useful for this case/topic?”

Let them know if a source they have used is not appropriate or if there is a better source for that particular type of information. Refer them to the resources listed in the Educational Program (Module 1, Getting the most from the program)

Notify Project Manager of problems with participants as early as possible
If you have problems notify the Project Manager, Jill Beattie, on 0414 835 408 as early as possible. Early intervention may help to resolve the problem or prevent it from escalating.

Refer pharmacist queries unrelated to discussion topics to the Project Manager
You are not expected to answer pharmacists’ questions relating to the design of the program and the web site (e.g. troubleshooting). Feel free to refer such queries to the Project Manager, Jill Beattie, on 0414 835 408 if necessary.

6. What is expected of participants?

Critical thinking and reflection
To aid discussion, some of the Activities within the program encourage the participants to join in on the Discussion Group comments.

If participants’ entries are only ‘agree’ or ‘disagree’ statements, without foundation support, you will need to encourage the discussion further. For example:

- Is the comment etc based on evidence or experience?
- Give a rationale for your agreements and disagreements with the points/comments raised
- Can you clarify that point further?
- What alternatives are there to………?

It is preferable for participants to draw from the program material and from their own life experience in responding to statements and questions. We are encouraging them to develop a critical approach to the material presented, to their own postings, and to others’ postings, through a reflective process. Participants should be encouraged to question the ideas presented. See Module 1: Getting the most from the program.

It is hoped that participants will develop their consultation, collaboration and networking skills as they reflect on the program material and interact with others in the Discussion Group.

However, it is also hoped that participants will develop intra-personal skills as they make choices about when, where, and how to respond to a concept or an idea.

A willingness to participate and collaborate with others
Participants are encouraged to participate in the Discussion Group, however, whether they do or not, and to what degree, will depend on the value they assign to this type of activity. Non-participation may be due to time constraints.
The establishment of an online identity
Participants are expected to voice their opinions/ideas/concepts in a non-competitive atmosphere. Participants should ‘type the way they speak’. By creating an online identity their comfort level for participation also increases because the process in many ways mimics the face-to-face classroom.

As participants become more comfortable in the text-based conversation setting, they become increasingly able to express their thoughts, emotions, frustrations and even gestures using symbolic or representative techniques (see Appendix 2 and 3).

7. Program administration, support and feedback

Recording the process

As you are aware, this educational program is part of a larger research project, therefore it is important to record (or journal) the processes that occur and decisions that are made as you moderate the Group. This is all valuable data.

Be aware however, that much of this information may already be documented in the postings, which will become part of the data as well – so, there is no need to duplicate something that comes through in the Discussion Group data.

However, where issues arise for you, you need to document these. For example any:

- decisions you make to contact other experts
- concerns you have regarding postings
- contact you have with the web-designer/Project Manager etc
- time issues for you e.g. how much of your time is actually spent in moderating the program
- anything you feel will be valuable data

Support

If you have any questions, problems or feedback regarding the Discussion Groups or the palliative cancer care educational program please contact:

Jill Beattie (Project Manager)
Department of Pharmacy Practice
Victorian College of Pharmacy
Monash University
381 Royal Pde, Parkville VIC 3052
Mobile: 0414 835 408
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OR

Safeera Hussainy (PhD Scholar)
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Monash University
381 Royal Pde, Parkville VIC 3052
Phone: 9903 9025
Fax: 9903 9629
E-mail: safeera.hussainy@vcp.monash.edu.au

References


125
Appendix 1: Using the Discussion Group

Extract from the web-based Discussion Group: Frequently Asked Questions

Using the Discussion Group

The **Discussion Group** gives the participant an opportunity to respond to various activities throughout the program, to raise issues, and to pose questions in relation to the **Pharmacists and Palliative Cancer Care** program. Your participation will also enable questions to be answered; and you will receive advice and support from experts in palliative cancer care. You can either contribute to pre-existing topics or create your own topic and invite others to make comment.

The image below displays part of the **Discussion Group** logon page. Before you can contribute to the Discussion group you must first register as a user. We have set up an anonymous user you can use so that all your posts are completely confidential. To login as an anonymous user just enter the user name 'anon' and password of 'password'. Alternatively you can also register using a name and password you select. In addition you will see a link to FAQ (see figure). Please take the time to read these since they will make your use of the groups much more productive.

Please also note that the **Discussion Group** is **Moderated**. Consequently any posting you make will not appear on the site until it has been cleared by the **Moderator**.

![Discussion Group Logon Page](http://svc0393.bne005w.server-web.com/images/default/icon_bar.gif)

**FAQ Table of Contents**

- Do I have to register?
- How can I use smilies and images?
- Can I add a hyperlink to my messages?
- Can I change the format of my text?
- What are Moderators?
- Are cookies used?
- What are active topics?
- Can I edit my own posts?
- Can I attach files?
- Can I search?
- Can I edit my profile?
- Can I attach my own signature to my posts?
- Are there any censor features?
- What does it mean if a forum has Moderation enabled?
- What is COPPA?
• Where can I get my own copy of this Forum?
• Can't find your answer here? Send us an e-mail.

Registering

Registration is not required to view current topics on the Forum; however, if you wish to post a new topic or reply to an existing topic registration is required. Registration is free and only takes a few minutes. The only required fields are your Username, which may be your real name or a nickname, and a valid e-mail address.

The information you provide during registration is not outsourced or used for any advertising by Pharmacists and Palliative Cancer Care.

If you believe someone is sending you advertisements as a result of the information you provided through your registration, please notify us immediately.

Smilies

You’ve probably seen others use smilies before in e-mail messages or other bulletin board posts. Smilies are keyboard characters used to convey an emotion, such as a smile "😊" or a frown "😊". This bulletin board automatically converts certain text to a graphical representation when it is inserted between brackets "[]". Here are the smilies that are currently supported by Pharmacists and Palliative Cancer Care:

<table>
<thead>
<tr>
<th>Smiley</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>smile</td>
<td>[:)]</td>
</tr>
<tr>
<td>big smile</td>
<td>[:D]</td>
</tr>
<tr>
<td>cool</td>
<td>[8D]</td>
</tr>
<tr>
<td>blush</td>
<td>[:I]</td>
</tr>
<tr>
<td>tongue</td>
<td>[:p]</td>
</tr>
<tr>
<td>evil</td>
<td>[]:)]</td>
</tr>
<tr>
<td>wink</td>
<td>[;)]</td>
</tr>
<tr>
<td>clown</td>
<td>[;o]</td>
</tr>
<tr>
<td>black eye</td>
<td>[B]</td>
</tr>
<tr>
<td>eightball</td>
<td>[8]</td>
</tr>
<tr>
<td>frown</td>
<td>[:()]</td>
</tr>
<tr>
<td>shy</td>
<td>[8]</td>
</tr>
<tr>
<td>shocked</td>
<td>[:0]</td>
</tr>
<tr>
<td>angry</td>
<td>[:(!]</td>
</tr>
<tr>
<td>dead</td>
<td>[xx()]</td>
</tr>
<tr>
<td>sleepy</td>
<td>[1)]</td>
</tr>
<tr>
<td>kisses</td>
<td>[:X]</td>
</tr>
<tr>
<td>approve</td>
<td>[^]</td>
</tr>
<tr>
<td>disapprove</td>
<td>[V]</td>
</tr>
<tr>
<td>question</td>
<td>[?]</td>
</tr>
</tbody>
</table>

Creating a Hyperlink in your message

You can easily add a hyperlink to your message.

All that you need to do is type the URL (http://svc0393.bne005w.server-web.com/), and it will automatically be converted to a URL (http://svc0393.bne005w.server-web.com/)!

The trick here is to make sure you prefix your URL with the http://, https:// or file://

You can also add a mailto link to your message by typing in your e-mail address.

This Example:
grant@msit.com.au
Outputs this:
grant@msit.com.au
Another way to add hyperlinks is to use the [url]linkto[/url] tags

This Example:
Outputs This:
http://svc0393.bne005w.server-web.com/ takes you home!

If you use this tag: [url="linkto"]description[/url] you can add a description to the link.

This Example:
Take me to [url="http://svc0393.bne005w.server-web.com/"]Pharmacists and Palliative Cancer Care[/url]
Outputs This:
Take me to Pharmacists and Palliative Cancer Care
This Example:
If you have a question [url="grant@msit.com.au"]E-Mail Me[/url]
Outputs This:
If you have a question E-Mail Me

<table>
<thead>
<tr>
<th>How to format text with Bold, Italic, Quote, etc...</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are several Forum Codes you may use to change the appearance of your text. Following is the list of codes currently available:</td>
</tr>
<tr>
<td><strong>Bold:</strong> enclose your text with [b] and [/b]. <em>Example:</em> This is <strong>bold</strong>[/b] text. = This is <strong>bold</strong> text.</td>
</tr>
<tr>
<td><em>Italic:</em> enclose your text with [i] and [/i]. <em>Example:</em> This is [<em>italic</em>][/i] text. = This is <em>italic</em> text.</td>
</tr>
<tr>
<td><strong>Underline:</strong> enclose your text with [u] and [/u]. <em>Example:</em> This is <strong>underline</strong>[/u] text. = This is <strong>underline</strong> text.</td>
</tr>
<tr>
<td><strong>Aligning Text Left:</strong> Enclose your text with [left] and [/left]</td>
</tr>
<tr>
<td><strong>Aligning Text Center:</strong> Enclose your text with [center] and [/center]</td>
</tr>
<tr>
<td><strong>Aligning Text Right:</strong> Enclose your text with [right] and [/right]</td>
</tr>
<tr>
<td><strong>Striking Text:</strong> Enclose your text with [s] and [/s]</td>
</tr>
<tr>
<td><em>Example:</em> [s]mistake[/s] = mistake</td>
</tr>
<tr>
<td><strong>Horizontal Rule:</strong> Place a horizontal line in your post with [hr]</td>
</tr>
<tr>
<td><em>Example:</em> [hr] =</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Font Colors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclose your text with [fontcolor] and [/fontcolor]</td>
</tr>
<tr>
<td><em>Example:</em> [red]Text[/red] = Text</td>
</tr>
<tr>
<td><em>Example:</em> [blue]Text[/blue] = Text</td>
</tr>
<tr>
<td><em>Example:</em> [pink]Text[/pink] = Text</td>
</tr>
<tr>
<td><em>Example:</em> [black]Text[/black] = Text</td>
</tr>
</tbody>
</table>
### Example:

- `[orange]Text[/orange] = Text`
- `[violet]Text[/violet] = Text`
- `[yellow]Text[/yellow] = Text`
- `[green]Text[/green] = Text`
- `[gold]Text[/gold] = Text`
- `[white]Text[/white] = Text`
- `[purple]Text[/purple] = Text`

### Headings:

Enclose your text with `[hnumber]` and `[/hnumber]`.

- `[h1]Text[/h1] = Text`
- `[h2]Text[/h2] = Text`
- `[h3]Text[/h3] = Text`
- `[h5]Text[/h5] = Text`

### Font Sizes:

- `[size=1]text[/size=1] = Text`
- `[size=2]text[/size=2] = Text`
- `[size=3]text[/size=3] = Text`
- `[size=5]text[/size=5] = Text`

### Bulleted List:

- `[*] and [/*]`, and items in list with `[*]` and `[/*]`.

### Ordered Alpha List:

- `[list=a] and [/list=a]`, and items in list with `[*]` and `[/*]`.

### Ordered Number List:

- `[list=1] and [/list=1]`, and items in list with `[*]` and `[/*]`.

### Code:

Enclose your text with `[code]` and `[/code].`

### Quote:

Enclose your text with `[quote]` and `[/quote].`

### Moderators

Moderators control individual forums. They may edit, delete, or prune any posts in their forums. If you have a question about a particular forum, you should direct it to your forum moderator.

### Cookies

These Forums use cookies to store the following information: the last time you logged in, your Username and your Encrypted Password. These cookies are stored on your hard drive. Cookies are not used to track your movement or perform any function other than to enhance your use of these forums. If you have not enabled cookies in your browser, many of these time-saving features will not work properly. **Also, you need to have cookies enabled if you want to enter a private forum or post a topic/reply.**

You may delete all cookies set by these forums in selecting the "logout" button at the
Active Topics

Active Topics are tracked by cookies. When you click on the "active topics" link, a page is generated listing all topics that have been posted since your last visit to these forums (or approximately 20 minutes).

Editing Your Posts

You may edit or delete your own posts at any time. Just go to the topic where the post to be edited or deleted is located and you will see a edit or delete icon on the line that begins "posted on..." Click on this icon to edit or delete the post. No one else can edit your post, except for the forum Moderator or the forum Administrator. A note is generated at the bottom of each edited post displaying when and by whom the post was edited.

Attaching Files

For security reasons, you may not attach files to any posts. However, you may cut and paste text into your post.

Searching For Specific Posts

You may search for specific posts based on a word or words found in the posts, user name, date, and particular forum(s). Simply click on the "search" link at the top of most pages.

Editing Your Profile

You may easily change any information stored in your registration profile by using the "profile" link located near the top of each page. Simply identify yourself by typing your Username and Password and all of your profile information will appear on screen. You may edit any information (except your Username).

Signatures

You may attach signatures to the end of your posts when you post either a New Topic or Reply. Your signature is editable by clicking on "profile" at the top of any forum page and entering your Username and Password.

NOTE: HTML can't be used in Signatures.

Censoring Posts

The Forum does censor certain words that may be posted; however, this censoring is not an exact science, and is being done based on the words that are being screened, so certain words may be censored out of context. Words that are censored are replaced with asterisks.

What does it mean if a forum has Moderation enabled?

**Moderation:** This feature allows the Administrator or the Moderator to "Approve", "Hold" or "Delete" a users post before it is shown to the public.

**Approve:** Only the administrators or the moderators will be able to approve a post made to a moderated forum. When the post is approved, it will be made viewable to the public.

**Hold:** When a user posts a message to a moderated forum, the message is automatically put on hold until a moderator or an administrator approves of the post. No one will be able to view the post while it is put on hold.

**NOTE: Authors of the post will be able to edit their post during this mode.**
Delete: If the administrator or moderator chooses this option, the post will be deleted and an e-mail will be sent to the poster of the message, informing them that their post was not approved. The administrator/moderator will be able to give their reason for not approving the post in the e-mail.

What is COPPA?

The Children's Online Privacy Protection Act and Rule apply to individually identifiable information about a child that is collected online, such as full name, home address, e-mail address, telephone number or any other information that would allow someone to identify or contact the child. The Act and Rule also cover other types of information -- for example, hobbies, interests and information collected through cookies or other types of tracking mechanisms -- when they are tied to individually identifiable information. More information can be found here.

Getting Your Own Forum

The most recent version of this Snitz Forum can be downloaded at this Internet website.

NOTE: The software is highly configurable, and the baseline Snitz Forum may not have all the features this forum does.

Pharmacists and Palliative Cancer Care

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Appendix 2: Guidelines for e-communication for the moderator

An abridged version of this material has been provided to the participants prior to them commencing the program. See Appendix 3.

It is important to understand the basics about writing on-line, so you can:
- Be properly understood
- Get your points across effectively
- Avoid annoying other participants

**Format**
- **DON’T WRITE EVERYTHING IN UPPERCASE!**
- Mixed-case text is more relaxing to read.
- Uppercase is sometimes used, when somebody wants to indicate that they are SHOUTING! But few people will read a message that SCREAMS at them.

When typing in a message:
- Keep sentences short
- Even phrases may accurately convey your message
- Break it up text into **paragraphs**. People often skip large blocks of text.
- Leave a space between paragraphs. This makes it easier to read.
- For further information on formatting you may wish use - click on Discussion Groups on the main menu bar, then click on Go to the Discussion Group, then in the top right-hand corner, click on FAQ (Frequently Asked Questions) – then refer to the FAQ Table of Contents. They have also been reproduced in Appendix 1 these guidelines.

**Brevity**
- Keep responses/comments short.
- Be concise - get to the point.
- Plan ahead. Before you start to type, **think first** about what you want to say.
- Jotting down notes before you type a message online will assist in getting your message across.

**Clarity**
- Check what you have written before you send it
- Reading it out loud will be a good check for clarity
- Avoid using **acronyms**. While some of these (such as BTW, which means ‘by the way’) are well known, you can’t be sure that all of your readers know what they mean.
- Net acronyms (BTW, ROFL, IIRC, IMNSHO, IANAL etc.) may seem ‘hip’, but if they confuse the reader, you may not get your point across.
- Avoid time-wasting **contractions**, such as “ur” for “your” or “cya” for “see you later”.
- Use symbols for emphasis e.g. “That *is* what I meant”.

**Quoting**
- ‘Quoting’ is where you include all or some of the original message that you are replying to at the beginning of your message.
  - If you are replying to a specific point or question raised in a message it is preferable that you do ‘quote’ that message, to give context to your reply.
  - You should only include **enough of the original message to put your reply into context**- edit out all the irrelevant material to keep your message brief.

- Avoid **‘step-laddering’**. Sometimes people quote entire messages that contain quotes from earlier messages, which in turn contains quotes from still earlier messages. Messages that contain ‘quotes in quotes in quotes’ are said to be step-laddering.
  - By the time the reader gets to your text, it is not clear what you are commenting on.
  - Once again, you should extract only a few sentences that accurately represent the topic you are writing about.
Appendix X

- When appropriate, alternate between quotes and your comments. Sometimes it is not possible to find a few sentences in the original message that clearly convey what the writer was talking about. Here is an example of selective quoting. The lines that start with the > symbol indicate text taken from the original message:

> So I said to him that Mac is better than Windows

There is a comparison report in this month’s issue of “Computer World”. It shows that each platform has unique advantages.

> The Mac interface was invented by Apple Computer

Did you know that the Mac interface was based on a design from the Xerox PARC center?

> Still, Mac’s are better than PC’s any day.

That really depends on what your application is, don’t you think?

In the example above, each comment is directly targeted at a specific comment made by the other person. Don’t force your readers to guess at what part of the original message you are talking about.

Avoid ‘Me-tooing’

- Some people quote a huge message, then place a brief comment at the end, such as “I agree with this” or “Me too!”. This can be annoying to the person who has to scroll all the way through the message, looking for the part that you wrote.
- Quote only a few important sentences that summarise the message adequately, and place your comment after that.
- Simply saying that you agree with something doesn’t add much to the conversation. Tell people why you agree? You can state some of the reasons that you feel the way you do. This way, you will look like a thoughtful person who thinks carefully about things and considers all the facts.

Etiquette

There are many ways to get people ‘net-annoyed’ with you.

The worst problem is something called ‘keyboard bravery’. When you are sitting comfortably in front of your computer, safe from the world, it is often tempting to write a message that is so harshly phrased that it is insulting. You should always read what you have written before you send your message. Not only will this help you spot errors in spelling, phrasing and grammar, but you may also notice that you don’t sound as friendly as you would like.

A good rule of thumb is to be conservative in what you send and liberal in what you receive. That is, you should not send heated messages (called ‘flames’) even if you are provoked. On the other hand, you shouldn’t be surprised if you get ‘flamed’ and it’s prudent not to respond to flames.

Remember that the recipients of your messages are human beings whose culture, language and humour have different points of reference from your own.

Use ‘smileys’ to indicate tone of voice, but use them sparingly.

You will find how to use smilies etc in this program by clicking on Discussion Groups on the main menu bar, then click on Go to the Discussion Group, then in the top right-hand corner, click on FAQ (Frequently Asked Questions) – then in the FAQ Table of Contents – go to How can I use smileys and images. They have also been reproduced in Appendix 1 these guidelines.

N.B.: Appendix 3 for these guidelines was a copy of the information sent to the participants – for the moderator’s information in Appendix R of this report.

Improving Medication Management of Palliative Care Patients: Enhancing the Role of Community Pharmacists

Documenting Interventions

Pharmacist’s Manual

Thank you for your participation in this community pharmacy research project
Prepared by:
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Dr Simon Wein, Department of Pain and Palliative Care, Peter MacCallum Cancer Centre
Dr Jennifer Marriott, Senior Lecturer, Department of Pharmacy Practice
Dr Maria Pisasale, Mercy Western Palliative Care
Mr Bill Scott, The Pharmacy Guild of Australia

Acknowledgements
We would like to thank Professor Gregory Peterson and his team from the University of Tasmania for allowing us to use a modified version of D.O.C.U.M.E.N.T., a classification system for drug-related problems and their resolution, and the manual used to train pharmacists on how to use D.O.C.U.M.E.N.T. (Peterson GM, Tenni PC, Hasan O, Reeve JF, Liauw C, Pekarsky B, Turner P. PROMISE: Pharmacy Recording of Medication Incidents and Services electronic documentation system. The Society Of Hospital Pharmacists Of Australia. 4th Biennial SHPA Clinical Conference - 29-31 October 2004).
Contents

1. Introduction  4-5
   Why am I documenting interventions?  4
   When will the documentation of interventions occur?  4
   Who else do I need to inform regarding the study?  4
   How long will it take to fill out the forms?  4-5
   What do I do once I have completed the intervention form?  5
   What happens to the information once it has been submitted?  5
   How do I use this training manual?  5

2. The Intervention Form  6
   Format  6
   General Requirements  6

3. Test Scenarios  7-9
   Scenario 1  7
   Scenario 2  7-8
   Scenario 3  8-9

Appendix 1- The Intervention Form  10-12
Appendix 2- Drug-Related Problems: Definitions and examples  13-18
Appendix 3- Recommendations: Definitions and examples  19-21
Appendix 4- Actions: Definitions and examples  22-23
Appendix 5- Acceptance: Definitions and examples  24-25
Appendix 6: Completed Intervention Forms for Test Scenarios  26-34
   Scenario 1 Answers  27-28
   Scenario 2 Answers  29-30
   Scenario 3 Answers  31-34
1. Introduction

*Why am I documenting interventions?*
As a participant in this study, you have agreed to document your interventions with designated palliative care patients and/or their carers recruited from Mercy Western Palliative Care in Melbourne. Documenting interventions with patients/carers will:
- Assist you during the program to monitor and review the recommendations you make to patients, carers and other health professionals.
- Assist you during the program to monitor and review your actions, and thus to make positive changes to your practice where necessary.
- Assist the researchers to evaluate the palliative cancer care program that has been developed for community pharmacists in Australia.

*When will the documentation of interventions occur?*
Documentation will commence two weeks prior (i.e. February 14th 2005) to the test group of pharmacists starting the educational program, and continue throughout the program (March 1st - May 1st 2005), until two weeks after (i.e. June 14th 2005) the test group completes the program.

*Who else do I need to inform regarding the study?*
- Before the study commences, the Mercy Western Palliative Care patient/carer will be asked to consult you when they visit the pharmacy.
- Please inform other pharmacists working at your pharmacy about the study, so that if the patient/carer visits the pharmacy on a day when you are not available and consults another pharmacist who is not involved in the study, you can follow-up what happened either with the patient/carer and/or the pharmacist. A phone-call to the patient/carer is recommended.
- Please document any interventions carried out by the other pharmacist.

*How long will it take to fill out the forms?*
- The intervention form has been designed to be quick and easy to complete.
- In trialling the average time taken was approximately 10 minutes, but the time will vary a little from intervention to intervention.
- It is recommended that you complete the form immediately after the intervention has occurred as:
  - the details will be fresh in your mind and the information provided by you will be more accurate;
  - the form will take less time to complete;
  - you won’t have to worry about completing the form later;
  - you will be able to fax it to the researcher immediately after; and
  - you will be able to reflect on what your actions were and perhaps reconsider contacting the person with (patient/carer/doctor/nurse/other) whom you made the intervention and providing further advice.

*What do I do once I have completed the intervention form?*
Please fax the completed intervention form to Safeera Hussainy on (03) 9903 9629 at the end of each day. This fax number is received into a secure area.
What happens to the information once it has been submitted?

- The researchers may ring you to clarify any details on the intervention form.
- The information on the forms will then be collated.
- After the intervention documentation process is complete (July 1st, 2005), each form will be reviewed by an Expert Review Panel.
- To ensure that the Panel can appropriately assess interventions made by you, we ask that you provide the researchers with a de-identified computer record of the patient’s medication history.
- The Panel will comprise:
  - Two pharmacists [Community & Hospital];
  - Two physicians [GP & Palliative Care Specialist];
  - Two nurses [Community & Hospital]; and
  - A Clinical Risk Manager.

How do I use this training manual?

- First review the intervention form (Appendix 1, p.10-12); a description of the format of the form is also provided (p.6).
- Then, consider the general requirements of the form (p.6).
- Now attempt documenting three different scenarios (p. 7-9) using the intervention form. Refer to the tools provided in Appendices 2 (p.13-18), 3 (p.19-21), 4 (p.22-23) and 5 (p.24-25); these provide definitions and examples of drug-therapy problems, recommendations, actions and acceptance respectively.
- Then review your answers using the completed examples for the three scenarios in Appendix 6 (p.26-34).

2. The Intervention Form

Format

Generally, the intervention form comprises 4 main sections (see Appendix 1):
1. Demographic information.
   a. Date of the Intervention (today’s date).
   b. Patient’s/Carer’s Code Number (assigned by Mercy Western Palliative Care).
   c. Pharmacist’s Initials (person who made the intervention).
2. Drug-Related Problem (DRP) and recommendation to resolve the problem.
3. Actions to investigate & resolve the problem.
4. Acceptance of resolution of the problem by the doctor/nurse/patient/carer/other.

General Requirements

- We ask that you document one or more problems associated with one drug only per form.
- The problem may also be due to the treatments (e.g. chemotherapy, radiotherapy), rather than the medicines, that the patient is having.
- Please provide brief descriptions of the drug-therapy problem and your recommendation(s); ensure that these are legible and can be read once they have been faxed.
• If your recommended intervention(s) is not accepted or is partially accepted by the
doctor/nurse/patient/carer/other, or the result of your recommended intervention(s) is
unknown, briefly describe why.
• In addition, we ask that you provide the researchers with a de-identified computer record of
the patient’s medication history.

3. Test Scenarios
• Now try completing the Intervention Form based on the three different scenarios below.
• If necessary, you may refer to the definitions and examples of drug-therapy problems
22-23) and acceptance (Appendix 5, p.24-25) provided.
• Don’t forget to check your answers to the scenarios against those provided in Appendix 6 (p
26-34)!

Scenario 1
Mr JB comes in to your pharmacy and presents with a script for Sodium Valproate (Epilim)
500mg 2 tablets daily. Your computer records tell you that he received Epilim 200mg 2
tables daily last time. You ask him if the strength of his medicine has changed, and he says no.
You inform Mr JB that the strength of Epilim prescribed this time is different and that you need
to contact the doctor to confirm if this change was intentional or not.

You contact the doctor and the doctor tells you that the strength of the Epilim prescribed this
time was a mistake. You correct the script accordingly and dispense Epilim 200mg.

You inform Mr JB that the strength of Epilim was not intentionally changed by the doctor and
that he will receive the same strength as before. You now complete the Intervention Form.

NB: Mr JB is using Epilim as an adjunct for pain relief from cancer.

Scenario 2
Mrs SL comes in to your pharmacy with a script for Morphine SR (MS Contin) 60mg twice
daily Your computer records tell you that she has been receiving this medicine for the past few
weeks. You ask Mrs SL what the doctor has prescribed the MS Contin for, and she tells you that
she is taking it for cancer pain. You then ask her if her pain is well controlled, and to rate her
pain on a scale of 1 to 10. She rates her pain as 7, and says that the Paracetamol (Panadol) she
takes for extra pain relief doesn’t really help. She takes about 4-5 tablets of Panadol in a day.

You think that Mrs SL needs to take something for her breakthrough pain. Your records tell you
that she hasn’t been prescribed any medicine for her breakthrough pain until now. You inform
her that there are stronger pain relief medicines available on prescription that can be used instead
of Panadol to ease the pain that she experiences throughout the day, and that these are similar to
morphine. Mrs SL is interested and gives consent for you to ring the doctor to suggest the use of
a medication for her breakthrough pain. Before ringing, you check the Analgesic Guidelines on
how to calculate the breakthrough dose (120 mg/6 = 20 mg of Oxycodone when required)
required for Mrs SL. You contact the doctor and suggest the use of Oxycodone (Oxynorm)
capsules 20mg when required.

The doctor disagrees with you and feels that an increase in the dose of the MS Contin is more
suitable. The doctor asks you to send Mrs SL back for a review of her pain so that an appropriate
dozen of Morphine can be prescribed. You inform Mrs SL that she needs to go back to the doctor
for review of her pain and that the dose of the MS Contin will most likely be increased by the
doctor. You advise her to not use Panadol anymore for the treatment of her breakthrough pain.
You now complete the Intervention Form.

**Scenario 3**

Mr CS comes in to your pharmacy with two scripts: one is for Tramadol (Tramal) SR 100mg
twice daily and the other is for Alendronate (Fosamax) 70 mg once weekly. Your computer
records tell you that he hasn’t received Tramal from your pharmacy before, but has received the
Fosamax before.

Your computer records also tell you that Mr CS is taking Sertraline (Zoloft) 50mg daily, which
can significantly interact with Tramal to cause serotonin syndrome. You ask Mr CS what the
Tramal is for, and he tells you that it is for his cancer pain, and that he has never had it before.
You inform him that Tramal interacts with Zoloft, and that you need to contact the doctor to
recommend a change to another analgesic. You also ask Mr CS if he has taken other analgesics
before, to which he replies no.

You contact the doctor and he tells you that he wasn’t aware that Tramal and Zoloft can interact
significantly, and that changing to another analgesic would be appropriate. You suggest
Panadeine Forte 1-2 tablets every 4-6 hours when required, and recommend Coloxyl & Senna 2
tables twice daily to be taken with it to prevent constipation as Mr CS will be using the
Panadeine Forte for a long period of time. The doctor agrees. You change the script for Tramal
to Panadeine Forte, dispense it, and go out to counsel the patient on how to take it and the
Coloxyl and Senna.

Mr CS asks you if he can take the Panadeine Forte at the same time as he takes the Fosamax.
Upon further questioning, you find that he hasn’t been taking the Fosamax first thing in the
morning, before other medications and remaining upright for 30 minutes after taking it, because
noone had told him to and he didn’t bother to read the label on the box. You explain to him that
it is important to take the Fosamax as intended otherwise it won’t work, and that he cannot take
the Panadeine Forte, Coloxyl and Senna, and Zoloft at the same time (or any other medicine).
You now complete the Intervention Form.
Appendix 1

The Intervention Form
1. Today’s Date ___________ 2. Patient’s/Carer’s Code No. ________________ 3. Pharmacist’s Initials ___________

### 4. Type & Description of Drug Related Problem [DRP] AND Recommendation to Resolve the Problem & its Description

<table>
<thead>
<tr>
<th>A) Category [Type of DRP]</th>
<th>B) Description of DRP</th>
<th>C) Recommendation to Resolve the Problem</th>
<th>D) Description of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug selection</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Duplication</td>
<td></td>
<td>□ Drug change</td>
<td></td>
</tr>
<tr>
<td>□ Drug Interaction</td>
<td></td>
<td>□ Drug brand change</td>
<td></td>
</tr>
<tr>
<td>□ Wrong drug</td>
<td></td>
<td>□ Drug formulation change</td>
<td></td>
</tr>
<tr>
<td>□ Wrong dosage form</td>
<td></td>
<td>□ Drug addition</td>
<td></td>
</tr>
<tr>
<td>□ Previous ADR/Allergy</td>
<td></td>
<td>□ Drug cessation</td>
<td></td>
</tr>
<tr>
<td>□ Other Drug selection problem</td>
<td></td>
<td>□ Other recommendation __________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No recommendation necessary</td>
<td></td>
</tr>
<tr>
<td><strong>Over or underdose, frequency &amp; duration</strong></td>
<td></td>
<td>□ Dose change</td>
<td></td>
</tr>
<tr>
<td>□ Dose too high</td>
<td></td>
<td>□ Dose frequency/schedule change</td>
<td></td>
</tr>
<tr>
<td>□ Dose too low</td>
<td></td>
<td>□ Duration change</td>
<td></td>
</tr>
<tr>
<td>□ Incorrect frequency</td>
<td></td>
<td>□ Other recommendation __________________</td>
<td></td>
</tr>
<tr>
<td>□ Incorrect duration</td>
<td></td>
<td>□ No recommendation necessary</td>
<td></td>
</tr>
<tr>
<td>□ Other Dose/Duration related problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Compliance</strong></td>
<td></td>
<td>□ Verbal Counselling</td>
<td>□ Written Counselling</td>
</tr>
<tr>
<td>□ Taking too little</td>
<td></td>
<td>□ Commence dose administration aid</td>
<td></td>
</tr>
<tr>
<td>□ Taking too much</td>
<td></td>
<td>□ Other recommendation _________________</td>
<td></td>
</tr>
<tr>
<td>□ Difficulty using dosage form</td>
<td></td>
<td>□ No recommendation necessary</td>
<td></td>
</tr>
<tr>
<td>□ Other Compliance problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Untreated indications</strong></td>
<td></td>
<td>□ Treatment recommended</td>
<td></td>
</tr>
<tr>
<td>□ Condition not treated</td>
<td></td>
<td>□ Refer: To □ GP □ PC Nurse □ Hospital</td>
<td></td>
</tr>
<tr>
<td>□ Condition not treated adequately</td>
<td></td>
<td>□ For medication review □ Other</td>
<td></td>
</tr>
<tr>
<td>□ Preventive therapy not initiated</td>
<td></td>
<td>□ Other recommendation _________________</td>
<td></td>
</tr>
<tr>
<td>□ Other Untreated indication problem</td>
<td></td>
<td>□ No recommendation necessary</td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring required</strong></td>
<td></td>
<td>□ Laboratory Monitoring</td>
<td></td>
</tr>
<tr>
<td>□ Laboratory Monitoring</td>
<td></td>
<td>□ Non-Laboratory Monitoring</td>
<td></td>
</tr>
<tr>
<td>□ Non-Laboratory Monitoring</td>
<td></td>
<td>□ Other recommendation _________________</td>
<td></td>
</tr>
</tbody>
</table>
### Please Turn Over- Continued on Page 2

4. Type & Description of Drug Related Problem (DRP) AND Recommendation to Resolve the Problem & its Description Continued

<table>
<thead>
<tr>
<th>A) Category [Type of DRP]</th>
<th>B) Description of DRP</th>
<th>C) Recommendation to Resolve the Problem</th>
<th>D) Description of Recommendation</th>
</tr>
</thead>
</table>
| Education or Information | □ Lack of knowledge/confusion about condition  
                            □ Lack of knowledge/confusion about therapy  
                            □ Other Education/Information problem       | □ Verbal Counselling  
                            □ Written Counselling  
                            □ Refer: To □ GP □ PC Nurse □ Hospital  
                            □ For medication review □ Other  
                            □ Other recommendation ____________________  
                            □ No recommendation necessary             |                                      |
| □ Non-clinical: the patient has a management problem unrelated to drug therapy e.g. can’t collect medications due to illness or financial difficulties, requires an authority script | □ Verbal Counselling  
                            □ Written Counselling  
                            □ Other recommendation ____________________  
                            □ No recommendation necessary             |                                      |
| □ Toxicity or Adverse reaction | □ Verbal Counselling  
                            □ Written Counselling  
                            □ Treatment recommended  
                            □ Refer: To □ GP □ PC Nurse □ Hospital  
                            □ For medication review □ Other  
                            □ Other recommendation ____________________  
                            □ No recommendation necessary             |                                      |

5. Actions by Pharmacist to Investigate & Resolve the Problem [Multiple actions possible for one situation]

<table>
<thead>
<tr>
<th>Action</th>
<th>Time Taken to Perform [if &gt; 1 hr, please state how long in the space provided]</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Resolved without referral to other sources of information</td>
<td>□ &lt; 1 min □ 1-5 mins □ 6-10 mins □ 11-30 mins □ 31-60 mins □ &gt; 1 hr</td>
</tr>
<tr>
<td>□ Sought Information: □ Written □ Software □ Internet □ Other</td>
<td>□ &lt; 1 min □ 1-5 mins □ 6-10 mins □ 11-30 mins □ 31-60 mins □ &gt; 1 hr</td>
</tr>
<tr>
<td>□ Contacted: □ Doctor □ Nurse □ Other Pharmacist □ NPS □ Drug Information Service □ Other</td>
<td>□ &lt; 1 min □ 1-5 mins □ 6-10 mins □ 11-30 mins □ 31-60 mins □ 1 hr</td>
</tr>
<tr>
<td>□ Discussion with patient/carer</td>
<td>□ &lt; 1 min □ 1-5 mins □ 6-10 mins □ 11-30 mins □ &gt; 30 mins □ &gt; 1 hr</td>
</tr>
<tr>
<td>□ Other</td>
<td>□ &lt; 1 min □ 1-5 mins □ 6-10 mins □ 11-31 mins □ &gt; 30 mins □ &gt; 1 hr</td>
</tr>
</tbody>
</table>

6. Acceptance of Pharmacist's Resolution of the Problem

□ Unknown □ Accepted □ Partially Accepted □ Not accepted
Appendix 2

Drug-Related Problems: Definitions and examples
# Drug Selection: Problems related to the choice of drug prescribed or taken

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
</table>
| Duplication             | • When there are no obvious adverse clinical effects of the 2 medicines together, but it is either inappropriate or very unusual to see them prescribed or used together as they are from the same therapeutic class.  
  • This also covers the situation where a person may be inappropriately taking 2 brands of the same medicine. | • Patient prescribed Maxolon + Stemetil  
  • Patient prescribed MS Contin + Kapanol  
  • Patient taking Coloxyl+ Coloxyl and Senna at the same time  
  • Patient taking Nilstat oral drops + Dakarin oral gel at the same time | • If the medicines involved are not of the same therapeutic class, then use Drug Interaction. |
| Drug Interaction        | • When there are no obvious adverse clinical effects of the drug interaction, but the interaction is serious enough to check if the doctor knows of it.  
  • When there is a likely serious interaction between the patient’s existing therapy & a newly prescribed or used medicine, but the patient hasn’t yet commenced taking the new medicine. | • Patient commenced on Tramal who is already taking Pethidine  
  • Patient commenced on Auroxir who is already taking Pethidine  
  • Patient requests to purchase an OTC Antacid when taking Vibramycin | • If the interacting medicine is of the same therapeutic class as part of the patient’s existing therapy, then use Duplication.  
  • If the interaction is causing, or is suspected of causing a noticeable effect of any sort, then use Toxicity or Adverse Reaction. |
| Wrong Drug              | • When the prescription was intended to mean a different medicine and there was an error.  
  • When the medicine being taken was prescribed correctly but was dispensed as the wrong drug. | • Patient supplied with and taking Oxycontin 1 bd, labelled as Oxynorm 1 bd  
  • Doctor prescribes Chlorpromazine 200mg bd but intended Carbamazepine 200mg bd | • If the medicine is felt to be inappropriate because of specific patient parameters such as poor renal function, then use Other Drug selection problem.  
  • If the medicine prescribed is unavailable for dispensing (either because your pharmacy has no stock or the manufacturer/distributor has no stock) then use Non-clinical. |
| • Wrong dosage form     | • When the formulation of the medicine is inappropriate or incorrect in terms of the intended use of the medicine.  
  Note: Off-license use of medicines in palliative care is common. Certain medicines may be used in a non-standard way to treat the patient’s symptoms. | • Vancomycin oral capsules prescribed to treat systemic infection | • If the patient has a physical problem with the administration of the dosage form as it is intended to be used (e.g. swallowing a particular form of the medicine whole, cannot appropriately insert suppositories, arthritis limiting the use of an inhaler) then use Difficulty using dosage form.  
  • If the difficulty is not a physical/technical one, and is related to lack of understanding of the use of the dose form, the use Lack of knowledge/confusion about therapy. |
| Previous ADR/Allergy    | • When a medicine or medicine class is prescribed for the patient to which there has previously been an adverse reaction or allergy. | • Lorazepam prescribed for a patient who had a rash when they took Clonazepam | ..... |
| Other Drug selection problem | • When there is a contraindication to the use of a medicine because of an underlying condition in the patient.  
  • When a less expensive or alternative brand is substituted purely for cost reasons.  
  • When a medicine is felt to be unnecessary based on the conditions the patient has.  
  • When the medicine being used is out of date or deteriorated in some other way.  
  • When you believe a more effective medicine is available and you suggest it to the doctor instead of the current therapy. | • Patient who is experiencing severe fatigue is prescribed Dexamethasone to treat cerebral metastases; long-term use of dexamethasone can contribute to fatigue by inducing myopathy, infection and other complications  
  • Maxolon prescribed and doctor contacted to change to Pramolin  
  • Patient commenced on Losec when they were taking Celebrex for bony metastases. Celebrex has been ceased, but they are still taking Losec  
  • Patient has Aspirin tablets for use that are over 2 years old and have been stored incorrectly. | • If a less expensive brand is substituted because the ordered brand is unavailable, then use Non-clinical.  
  • If the patient is currently experiencing symptoms of toxicity, then use Toxicity or Adverse Reaction. |
### Over or underdose, duration and frequency: Problems related to the prescribed dose, duration or schedule of the drug

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
</table>
| **Dose too high**             | • When the total daily dose of a medicine prescribed is too high for the patient, either based on previous dosage or reference dosage ranges.  
  • Includes the situation where the dose is too high because of a particular parameter of the patient such as renal function, weight, age.  
  • Includes situations where the dose that is prescribed is too high by error.  
  **Note:** The use of high doses of certain medicines (e.g. opioids for pain) in palliative care is common. These medicines most often do not have a ‘ceiling dose’ or are given in doses that are higher than the standard reference dosage range in order to treat symptoms adequately. | • Patient prescribed *Diamicron MR* 180mg m  
  • Patient prescribed *Dexamethasone* 50mg d  
  [reference dosage range = 2-20mg d] because doctor was thinking of prednisolone dose  
  • Patient prescribed *Spirolactone* 100mg bd for heart failure | If the patient is taking too high a dose as a result of not following the appropriate directions, then use *Taking too much*. |
| **Dose too low**              | • When the dose prescribed is either too low based on previous therapy or reference dosage ranges.  
  • Includes situations where the dose that is prescribed is too low by error.  
  **Note:** The use of low doses of certain medicines (e.g. anti-hypertensives for dysuria) in palliative care is common. These medicines are given in doses that are lower than the standard reference dosage range in order to treat symptoms adequately. | • Locum doctor prescribes *Epilim* 500mg bd, when previous therapy was 200mg bd  
  • Patient is using one *Durogesic* 25 mcg/hour patch every 2 days instead of every 3 days; indicates that the patient’s pain is not well controlled because patch strength is too low, should be increased to 75 mcg/hour strength | • If the actual dose per day is suitable, but the duration is too short, then use *Incorrect duration*.  
  • If the patient is taking too low a dose as a result of not following the appropriate directions, then use *Taking too little*. |
| **Incorrect frequency**       | When the total dose of a medicine is suitable, but the frequency or the dosage schedule is inappropriate. | • *Kapanol* prescribed as tds rather than bd | If the patient is not taking the medicine according to the correct frequency as a result of a lack of understanding of the regimen, then use *Lack of knowledge/confusion about therapy*. |
| **Incorrect duration**        | When the duration of use of a medicine is too short or too long. | Patient prescribed *Aropax* 20mg d for 2 weeks for depression | If the patient is not taking the appropriate dose of a medicine as a result of a lack of understanding of the dosage regimen, then use *Lack of knowledge/confusion about therapy*. |
| **Other Dose/Duration related problem** | When the pharmacist thinks that the patient has any other problem relating to the dose/duration/frequency of a medicine that requires management. | • Patient prescribed *Diamicron MR* 180mg m  
  • Patient prescribed *Dexamethasone* 50mg d  
  [reference dosage range = 2-20mg d] because doctor was thinking of prednisolone dose  
  • Patient prescribed *Spirolactone* 100mg bd for heart failure | --- |

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**Appendix Y**

147
### Compliance: Problems related to the way the patient takes the drug

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking too little</td>
<td>When the patient uses too little of a medicine as a result of forgetfulness or lack of understanding of the dosage regimen prescribed.</td>
<td>- Patient taking <em>MS Contin</em> only when required rather than regularly&lt;br&gt;- Patient using Lactulose mixture only every few days, not regularly as prescribed to prevent constipation from <em>Oxycontin</em>&lt;br&gt;- Patient not taking medicine because they believe it will “stop working later on”</td>
<td>- If the underscore is appropriate because of the resolution of symptoms or a condition, then use Other Drug selection problem and specify that the drug may no longer be required.&lt;br&gt;- If the patient has a physical problem with the administration of the dosage form as it is intended to be used [e.g. swallowing a particular form of the medicine whole, cannot appropriately insert suppositories, arthritis limiting the use of an inhaler] then use Difficulty using dosage form.</td>
</tr>
<tr>
<td>Taking too much</td>
<td>When the patient uses too much of a medicine as a result of forgetfulness or lack of understanding of the dosage regimen prescribed.</td>
<td>- Patient using <em>Durogesic</em> patches every day instead of every 3 days&lt;br&gt;- Patient continuing to take 50mg daily of Prednisolone, had forgotten to commence a dose reduction schedule as instructed by the doctor</td>
<td>- If the overuse is due to an appropriate increase in use because of increased symptoms, then use Condition not treated adequately.&lt;br&gt;- If the overuse consists of inappropriately taking 2 different brands or forms of the same drug unknowingly, then use Duplication.</td>
</tr>
<tr>
<td>Difficulty using dosage form</td>
<td>- When the patient has a physical problem with the administration of the dosage form or device as it is intended to be used [e.g. swallowing a particular form of the drug whole, cannot appropriately insert suppositories, requires all medicines to be crushed or administered as a liquid form due to swallowing difficulties/is on a feeding tube, arthritis limiting the use of an inhaler].&lt;br&gt;- When the patient has a technical problem with the use of the dosage form or device as it is intended to be used.</td>
<td>- Patient cannot swallow her controlled release <em>Kapanel</em> capsules&lt;br&gt;- Patient with scoliosis cannot insert suppositories&lt;br&gt;- Controlled release tablet ordered for a patient who is on a feeding tube and must crush all oral drugs</td>
<td>If the difficulty is not a physical/technical one, and is related to lack of understanding of the use of the dose form, the use Lack of knowledge/confusion about therapy.</td>
</tr>
<tr>
<td>Other Compliance problem</td>
<td>When the patient is aware of the way to take the medicine, is physically able to take the medicine, and understands its purpose, but does not wish to take it (e.g. may be due to cultural/religious beliefs).</td>
<td>- Patient unwilling to use <em>MS Contin</em> because they think they will become ‘addicted to it’.&lt;br&gt;- Patient unwilling to use Haloperidol after reading the package insert</td>
<td>- If the compliance issue results in 2 medicines of the same therapeutic class being taken inadvertently, then use Duplication.&lt;br&gt;- If the patient doesn’t wish to take the drug because it’s causing an adverse event, then use Toxicity or Adverse reaction.</td>
</tr>
</tbody>
</table>

### Untreated indications: Problems related to the actual or potential conditions that require management

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition not treated</td>
<td>When the patient has a symptom or disease condition that is not being treated.</td>
<td>Patient has constipation caused by <em>Oxycontin</em>; a laxative was not initially prescribed with the <em>Oxycontin</em> as a preventative treatment</td>
<td>If the patient requires additional therapy as a preventative strategy [e.g. potassium when on a loop diuretic] then use Preventive therapy not initiated.</td>
</tr>
<tr>
<td>Condition not treated</td>
<td>When the patient has a symptom or disease condition that is not being treated adequately.</td>
<td>- Patient taking <em>MS Contin</em> 60mg bd but the pain remains uncontrolled&lt;br&gt;- Patient taking self-prescribed OTC Ginger tablets but the nausea remains uncontrolled&lt;br&gt;- Patient taking Glycerol suppositories but the constipation remains</td>
<td>If the patient requires additional therapy as a preventative strategy [e.g. potassium when on a loop diuretic] then use Preventive therapy not initiated.</td>
</tr>
<tr>
<td>Preventive therapy not</td>
<td>When the patient requires additional therapy to prevent a likely adverse event as a result of the patient’s therapy, co-existing diseases or risk factors.</td>
<td>Patient commences on <em>Oxycontin</em> and you suggest the addition of Colonyl and Senna</td>
<td>If the patient already has treatment for a particular problem, but it is not effective enough, then use Condition not treated adequately.</td>
</tr>
<tr>
<td>Other Untreated</td>
<td>When you think the patient has any condition that is not being treated.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Monitoring required: Problems related to monitoring the efficacy or adverse effects of a drug

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Laboratory Monitoring</strong></td>
<td>• When, in the absence of any adverse effects, you believe that a laboratory test is required [e.g. potassium, creatinine, white cell count, INR].</td>
<td>• Patient recently had Furosemide dose increased from 40mg d to 120mg d without a change in potassium replacement; you recommend plasma potassium measurement</td>
<td>• If there are adverse effects associated with the parameter, then use Toxicity or Adverse reaction and specify the parameter to be tested and the symptom/sign [e.g. patient with leg cramps, suggest magnesium level].</td>
</tr>
<tr>
<td></td>
<td>• When, in the absence of any adverse effects, you believe that drug level monitoring is required.</td>
<td>• Patient commenced on Avanza and you recommend a white cell count</td>
<td>• If the need for laboratory level monitoring comes about as a result of a newly commenced medicine that interacts with a currently prescribed medicine, then use Drug Interaction. The monitoring then becomes a recommendation, not the primary problem.</td>
</tr>
<tr>
<td></td>
<td>• Elderly woman on Digoxin, who has not had a plasma digoxin test for 2 years</td>
<td>• A patient with cancer pain has an appropriate increase in his dose of MS Contin and you advise him to monitor his pain each day (using a symptom diary and the Edmonton Symptom Assessment System) for the next week.</td>
<td>If you recommend monitoring of a parameter [e.g. weight, BSL] as a result of another drug problem, then that recommendation should be recorded in the Recommendation to Resolve the Problem section. The type of problem that leads to this recommendation may vary.</td>
</tr>
<tr>
<td><strong>Non-laboratory Monitoring</strong></td>
<td>• When, in the absence of any adverse effects, you believe that non-laboratory monitoring is required [e.g. blood pressure, temperature, symptom diary/visual analogue scales (like the Edmonton Symptom Assessment System) to monitor symptoms such as pain, nausea, depression, appetite and shortness of breath]. Also covers the situation where the test is undertaken as a screening process.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Education or Information: Problems related to knowledge of the disease or its management

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of knowledge/confusion about condition</strong></td>
<td>When the patient does not have a reasonable understanding of a condition they have or a fundamental aspect of a condition they have</td>
<td>Patient has anorexia caused by cancer and is not aware of the need for dietary management (frequent, small meals; soft, cold foods; caffeine-containing beverages 30 minutes before meals etc.)</td>
<td>If the confusion would have [or did] result in a change in treatment [either taking too much or too little of the drug], then use Compliance</td>
</tr>
<tr>
<td><strong>Lack of knowledge/confusion about therapy</strong></td>
<td>When the patient does not understand the reasons for use of a medicine, but they still take it [either as directed or not]</td>
<td>When providing a new prescription for Dexamethasone for a patient with newly diagnosed dyspnoea caused by cancer, you find that she believes that the medicine may cure the condition and she can stop the medicine in a few months</td>
<td>If the confusion would have [or did] result in a change in compliance [either taking too much or too little of the drug], then use Compliance.</td>
</tr>
</tbody>
</table>
| **Other Education/Information problem** | • When another health care provider [e.g. doctor/nurse/pharmacist] requests information.  
• Also covers any other education or information related problem.  | • The GP wants to prescribe Octreotide for the management of a patient’s bowel obstruction but is not aware of the procedure to access it on the Special Access Scheme. The GP requests this information.  
• The nurse wants to know if she can mix Ketamine and Cyclizine together in a syringe driver for a patient  | ----- |

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Appendix Y

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149
### Non-clinical: The patient has a management problem unrelated to drug therapy

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
</table>
|              | - When a prescription that appears not to be bona fide and requires confirmation of its legality by the prescriber  
- When the prescription does not meet PBS requirements  
- When the medicine is unavailable from the manufacturer or is out of stock temporarily  
- When the dose of the medicine is not specified on the prescription  
- When the prescriber is not authorised to prescribe that particular medicine  
- When the patient has problems getting to the pharmacy or collecting prescriptions | - Phythoptone 5mg tablets not available, substitute 10mg tablets with dose adjustment  
- Patient requires *Rivotril* drops urgently. Your pharmacy does not stock them; you ring other pharmacies to determine if they stock the medicine.  
- Patient requires wound dressings but cannot collect them because they are ill (carer is not available either); you offer to home-deliver the dressings. | If a less expensive or alternative brand is substituted purely for cost reasons, then use Other Drug selection problem and specify brand substitution for cost reasons |

### Toxicity or Adverse reaction: Problems related to the presence of signs or symptoms which are suspected to be related to an adverse effect or toxicity of a drug

<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
</table>
|              | - When the patient has signs or symptoms that suggest an adverse reaction. Also where compliance issues have lead to symptoms of toxicity.  
- When the patient has signs or symptoms that suggest an adverse reaction that relates to the presence of an interacting medicine.  
- When there are symptoms of toxicity but the cause is not due to interaction or dose but there is a suspected likely drug cause | - Patient had their dose of *Tramadol* increased and develops headache, sweating & agitation  
- Promethazine & Amitriptyline together causing worsening of dry mouth  
- Patient develops hypotension after commencing *Prazosin*, even though the dose is controlling the dysuria | - If the patient does not have any signs or symptoms of adverse effects and you believe the dose is too high, then use *Dose too high*.  
- If the patient has an interacting drug present, but there are no signs or symptoms of the interaction causing an adverse effect, then use *Drug Interaction*. Also where the patient has been prescribed interacting drugs but has not taken |
Appendix 3

Recommendations: Definitions and examples
<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug change</td>
<td>When the pharmacist recommends a change of the medicine to another in consultation with the doctor/prescriber.</td>
<td>• Patient describes ongoing drowsiness in the mornings with Nitrazepam, and the pharmacist suggests to the patient a change to Temazepam. • Pharmacist suggests patient does not take a medicine for a day and to go to the doctor to discuss the problem.</td>
<td>• If the change in medicine is simply a brand change, then use Drug brand change. • If the change in medicine is simply a change in formulation [e.g. from cream to ointment, or plain tablets to controlled release], then use Drug formulation change.</td>
</tr>
<tr>
<td>Drug brand change</td>
<td>When the pharmacist suggests a change in the brand of the medicine Note: pharmacists, as part of their standard professional practice, may suggest a change in the brand of the medicine, without contacting the doctor/prescriber (‘brand substitution not permitted’ box on the prescription should not be ticked and the patient/carer should be willing).</td>
<td>Maximum unavailable, pharmacist suggests that Pramin could be substituted.</td>
<td>If the change in brand is to a different formulation of the same active ingredient, then use Drug formulation change.</td>
</tr>
<tr>
<td>Drug formulation change</td>
<td>When the active ingredient of the medicine and its total daily dose is not changed, but the formulation is changed, in consultation with the doctor/prescriber.</td>
<td>• Pharmacist suggests a change from a metered dose inhaler to an aerosol. • Pharmacist suggests a change from cream to ointment as the cream is not available.</td>
<td>If the formulation change also results in a change in the total daily dose of the medication, then use Dose change.</td>
</tr>
<tr>
<td>Drug addition</td>
<td>When the pharmacist recommends the addition of a medicine, preferably in consultation with the doctor Note: pharmacists, as part of their standard professional practice, may recommend OTC medicines/products without contacting the doctor/prescriber first.</td>
<td>Pharmacist suggests the addition of Coloxyl and Senna to prevent constipation in a patient that is taking MS Contin.</td>
<td>-----</td>
</tr>
<tr>
<td>Drug cessation</td>
<td>When the pharmacist recommends the cessation of a medicine, in consultation with the doctor/prescriber.</td>
<td>• Pharmacist suggests the cessation of Fioxx because it has been recalled by the manufacturer. • Pharmacist suggests the cessation of Coversyl and Pravachol in a palliative care patient who is in the terminal stage and thus doesn’t require these medicines (only requires medicines necessary for symptom control).</td>
<td>-----</td>
</tr>
<tr>
<td>Dose change</td>
<td>When the pharmacist recommends a change in the total daily dose of the medicine, in consultation with the doctor/prescriber.</td>
<td>Pharmacist suggests increasing the dose of Seretide 250/50 from 1 puff d to 1 puff bd before the winter season starts in an asthmatic patient.</td>
<td>-----</td>
</tr>
<tr>
<td>Dose frequency/schedule change</td>
<td>When the pharmacist suggests a change in the number of times a day the medicine is taken, or in the timing of the doses each day but where the total daily dose remains the same. The pharmacist suggests this change with or without consulting the doctor/prescriber, depending on the situation, the medicine itself etc.</td>
<td>• Pharmacist suggests changing Epilim from 1g bd to 500mg qid to reduce gastric upset. • Pharmacist suggests changing in timing of Tegetol from morning and midday to morning and night to cover pain at night.</td>
<td>When the change results in a change in the total daily dose of the medication, use Dose change.</td>
</tr>
<tr>
<td>Duration change</td>
<td>When the pharmacist suggests a change in the duration/length of therapy, in consultation with the doctor/prescriber.</td>
<td>Pharmacist suggests that Nizoral be used for 2 weeks instead of 1 week to completely clear the patient’s oral candidiasis.</td>
<td>-----</td>
</tr>
<tr>
<td>Verbal Counselling</td>
<td>When the pharmacist conducts a detailed verbal counselling/education session with the patient/carer/doctor/nurse/other that is specifically targeted at resolving the problem that has been identified.</td>
<td>Patient was not taking Prednisolone correctly, pharmacist provided verbal instructions on how to take it and when.</td>
<td>-----</td>
</tr>
<tr>
<td>Written Counselling</td>
<td>When the pharmacist provides written counselling/education to the patient/carer/doctor/nurse/other that is specifically targeted at resolving the problem that has been identified.</td>
<td>Patient was not using Duragestic patches correctly, pharmacist provided CMI (covering all aspects including how to use it, how long it lasts, how to discard it when used).</td>
<td>-----</td>
</tr>
<tr>
<td>Sub-Category</td>
<td>When to Use</td>
<td>Examples of When to Use</td>
<td>When Not to Use</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Commence dose administration aid</td>
<td>When the pharmacist suggests the use of a dose administration aid such as a Dosette box or a Webster pack.</td>
<td>You recommend a Webster pack for a patient who has significant problems with understanding of the schedule and timing of their medications.</td>
<td>If you provide a written summary of the patient’s medicines &amp; their schedule in addition to the dose administration aid, then also select Written Counselling.</td>
</tr>
<tr>
<td>Treatment recommended</td>
<td>When the pharmacist suggests to the patient/carer/doctor/nurse/other the use of a treatment for an untreated indication or toxicity/adverse reaction that a patient has experienced.</td>
<td>You recommend to the doctor the use of Oxynorm in addition to the MS Contin for the treatment of the patient’s breakthrough pain.</td>
<td></td>
</tr>
<tr>
<td>Referral to: Prescriber/PC Nurse/Hospital/For Medication Review/Other</td>
<td>• When the problem is of sufficient seriousness for the patient to see the prescriber/palliative care nurse/hospital again in order to resolve the problem.</td>
<td>• Patient presents with a rash from the recently commenced antibiotics. You tell the patient to cease the medicine and refer her back to the prescriber for some different antibiotics.</td>
<td>When you undertake an “informal” review of the medications and generally assist with the patient’s understanding, use Verbal/Written Counselling.</td>
</tr>
<tr>
<td></td>
<td>• When the problem is of sufficient seriousness for the patient to see another health professional in order to resolve the problem.</td>
<td>• Patient presents with melena after commencing a non-steroidal anti-inflammatory.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When the pharmacist commences the process for a Home Medicines Review for the patient.</td>
<td>• You recommend a HMR for a patient who has significant problems with understanding their medicines.</td>
<td></td>
</tr>
<tr>
<td>Laboratory Monitoring</td>
<td>When the pharmacist suggests to the prescriber that they undertake some laboratory monitoring for efficacy or adverse effects from the medicine.</td>
<td>You contact the prescriber to suggest that he check the INR in a patient taking Warfarin who has commenced Amiodarone.</td>
<td>When the monitoring relates to a test that can be done at home [e.g. BSL] then use Non-Laboratory Monitoring.</td>
</tr>
<tr>
<td>Non-Laboratory Monitoring</td>
<td>When the pharmacist suggests that the patient undertake some non-laboratory monitoring for the efficacy or adverse effects from the medicine.</td>
<td>Pharmacist suggests the patient keeps a diary of their pain symptoms (and how often they are using e.g. breakthrough medicines), to determine if their pain is well controlled or not by the medicines prescribed.</td>
<td>When the monitoring involves a laboratory-based test, then use Laboratory Monitoring.</td>
</tr>
<tr>
<td>Other Recommendation</td>
<td>When the pharmacist suggests an option that is not related to any of the other categories.</td>
<td>Pharmacist offers to drop the medicines at their home because the patient can’t collect them.</td>
<td></td>
</tr>
<tr>
<td>No Recommendation Necessary</td>
<td>When the pharmacist has investigated a problem, but finds that the problem does not need to be addressed with any changes or monitoring.</td>
<td>Pharmacist receives a script from the patient and finds the dose is different from the last time the patient had the drug dispensed, then checks with the patient that the dose change was intentional</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Actions: Definitions and examples
<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolved without referral to other sources of information</td>
<td>When the problem can be resolved without referral to other sources of information or using existing knowledge.</td>
<td>A patient asks you if it’s ok to crush Maxolon tablets as they are too big to swallow whole-you say yes without consulting a reference-it is standard knowledge- and can be done so without affecting bioavailability etc. of the medication.</td>
<td>——</td>
</tr>
</tbody>
</table>
| Sought information: Written/Software/Internet/Other | When the pharmacist consults written reference material/decision support software [e.g. Palliative Care Guidelines] that is located on the computer or server in the pharmacy/internet/other [e.g. dispensing patient history]. | • You check the dose of Dilantin Paediatric oral liquid, in the Royal Children’s Hospital Pharmaciepia, prescribed for tremors in a 10 year old child with cancer  
• You check if Maxolon can be used in breastfeeding by accessing the PI from the e-PPG  
• You check which doctors the patient has visited to obtain Temaze tablets | ——                   |
| Contacted: Doctor/Nurse/Pharmacist/NPS/Drug Information Service/Other | • When the pharmacist needs to contact the doctor/prescriber to clarify their intent, provide new information from a patient encounter or to discuss recommendations the pharmacist may wish to make.  
• When the pharmacist needs to contact the nurse to provide new information from a patient health-related information from the nurse’s case history notes or to discuss recommendations that the pharmacist may have.  
• When the pharmacist needs to contact another pharmacist to obtain drug-related information, to check if they have a particular medicine in stock, or obtain other information  
• When the pharmacist needs to contact the National Prescribing Service/Drug Information Service to obtain drug-related information.  
• When the pharmacist needs to contact others [e.g. the manufacturer or supplier of the product, Health Insurance Commission] for information. | • Pharmacist rings the doctor to confirm that the dose increase for Tramadol was intentional, as the patient was unaware of any change  
• Pharmacist rings the nurse to fax the most recent medicine chart written for a patient in an aged care facility  
• Pharmacist contacts a colleague who works at the same pharmacy to clarify a problem  
• Pharmacist rings the pharmacy where the prescription was previously dispensed to clarify an issue  
• Pharmacist emails the National Prescribing Service to determine information about a new anti-cancer medicine that has not yet been released  
• Pharmacist contacts the Health Insurance Commission to determine the details of a particular Authority script arrangement | If as a result of investigating the problem you refer the patient to a prescriber, but do not contact the prescriber first, then use Other. |
| Discussion with patient/carer                    | When a discussion with the patient/carer takes place that is primarily aimed at clarifying a drug-related problem. | Pharmacist receives a script from the patient/carer and finds the dose is different from the last time the patient had the medicine dispensed, then checks with the patient/carer that the dose change was intentional | ——                   |
| Other                                            | When the pharmacist carries out an action to investigate & resolve the problem that does not fit into any of the above categories. | Pharmacist refers patient/carer to the prescriber without contacting the prescriber first | ——                   |
Appendix 5

Acceptance: Definitions and examples
<table>
<thead>
<tr>
<th>Sub-Category</th>
<th>When to Use</th>
<th>Examples of When to Use</th>
<th>When Not to Use</th>
</tr>
</thead>
</table>
| Unknown              | When the pharmacist is unaware of what happened after he/she made the        | • Pharmacist suggests that the patient go and see the doctor and they say they will think about it  
• Pharmacist leaves a message for the doctor to contact the patient/carer about the problem                                                                 | -----                                                                                                               |
|                      | recommendation(s).                                                           |                                                                                                                                                                                                                       |                                                                                                                     |
| Accepted             | When all of the recommendation(s) that the pharmacist makes are accepted.    | • Pharmacist contacts the doctor to suggest a reduction of the dose of Tramul and he/she accepts your suggestion  
• Pharmacist takes the time to explain fully the medicines and disease a patient has                                                                                      | If you make multiple recommendations and not all of them are accepted, then use Partially Accepted.                |
| Partially Accepted   | When the pharmacist makes multiple recommendations and only some of them are accepted. | • Pharmacist contacts the doctor to suggest reduction of the dose of Tegretol and a repeat blood level. He/she agrees with the reduction in dose, but thinks the blood level could be a waste of time  
• Pharmacist suggests to the patient that they withhold their Panadine Forte for a few days and go back to the doctor and ask for a different medicine. They decide to stop the medicine for a while, but choose not to go to the doctor |
|                      |                                                                              |                                                                                                                                                                                                                       | -----                                                                                                               |
| Not Accepted         | When all of the recommendation(s) that the pharmacist makes are not accepted. | Pharmacist contacts the doctor to suggest a reduction in the dose of Oxycontin and he says that he still wants to use that dose as the patient’s pain warrants it                                                                 | -----                                                                                                               |
Appendix 6

Completed Intervention Forms for Test Scenarios

N.B. These were blank documentation forms for the pharmacists to practice using the scenarios given in the Training Manual
Expert Review Panel Assessment forms
1. Today’s Date ______________  2. Patient’s/Carer’s Code Number ______________  3. Panel Member’s Code Number ______________

4. Expert Review Panel Member Assessment of Impact of Clinical Scenario prompting Pharmacist Intervention
   a) Actual or Potential Consequence or Impact on the Individual

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Description- What is the actual or potential consequence/impact of the scenario/event if the pharmacist did not intervene? [standard, not worst case scenario]</th>
</tr>
</thead>
</table>
| ☐ 1   | Insignificant | Did not affect symptom control, no development of new symptoms, no treatment needed  
|       |             | Did not impact on welfare of patient and/or family  
|       |             | No financial cost |
| ☐ 2   | Minor       | Minor decrease in symptom control, development of 1 new symptom, minor treatment needed, visit to general practitioner not required &/or admission to hospital not necessary  
|       |             | Minor impact on welfare of patient and/or family  
|       |             | Minor cost |
| ☐ 3   | Moderate    | Moderate decrease in symptom control, development of 1-2 new symptoms, modest treatment needed, visit to general practitioner required &/or admission to hospital necessary  
|       |             | Moderate impact on welfare of patient and/or family  
|       |             | Potential for moderate cost |
| ☐ 4   | Major       | Major decrease in symptom control, development of > 2 new symptoms, major treatment needed, visit to general practitioner required &/or admission to hospital necessary  
|       |             | Major impact on welfare of patient [morbidity after visiting general practitioner, morbidity on discharge from hospital] and/or family  
|       |             | Potential for major cost |
| ☐ 5   | Catastrophic| Death  
|       |             | Catastrophic impact on welfare of family  
|       |             | Major cost |

b) Likelihood of Re-occurrence in Same or Other Patients

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Description- What is the likelihood of the scenario/event re-occurring? [for a different patient]</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A</td>
<td>Almost certain</td>
<td>Almost certain to re-occur in most circumstances</td>
</tr>
<tr>
<td>☐ B</td>
<td>Likely</td>
<td>Likely to re-occur in most circumstances</td>
</tr>
<tr>
<td>☐ C</td>
<td>Possible</td>
<td>Will possibly re-occur at some time</td>
</tr>
<tr>
<td>☐ D</td>
<td>Unlikely</td>
<td>Unlikely to re-occur at some time</td>
</tr>
<tr>
<td>☐ E</td>
<td>Rare</td>
<td>May rarely re-occur in exceptional circumstances</td>
</tr>
</tbody>
</table>
c) **Classification of Risk (Likelihood of Re-occurrence x Actual or Potential Consequence/Impact)**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>A</td>
<td>H</td>
</tr>
<tr>
<td>B</td>
<td>M</td>
</tr>
<tr>
<td>C</td>
<td>L</td>
</tr>
<tr>
<td>D</td>
<td>L</td>
</tr>
<tr>
<td>E</td>
<td>L</td>
</tr>
</tbody>
</table>

**RISK**

- E- Extreme
- H- High
- M- Moderate
- L- Low
3. Expert Review Panel Members Summary Assessment of the Clinical Scenario prompting Pharmacist’s Intervention

a) **Actual or Potential Consequence or Impact on the Individual**

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Description- What is the actual or potential consequence/impact of the scenario/event if the pharmacist did not intervene? [standard, not worst case scenario]</th>
<th>No of Votes</th>
<th>Consensus Assessment</th>
</tr>
</thead>
</table>
| □ 1   | Insignificant | Did not affect symptom control, no development of new symptoms, no treatment needed  
Did not impact on welfare of patient and/or family  
No financial cost                                                                 |              |                     |
| □ 2   | Minor      | Minor decrease in symptom control, development of 1 new symptom, minor treatment needed, visit to general practitioner not required &/or admission to hospital not necessary  
Minor impact on welfare of patient and/or family  
Minor cost                                                                 |              |                     |
| □ 3   | Moderate   | Moderate decrease in symptom control, development of 1-2 new symptoms, modest treatment needed, visit to general practitioner required &/or admission to hospital necessary  
Moderate impact on welfare of patient and/or family  
Potential for moderate cost                                                                 |              |                     |
| □ 4   | Major      | Major decrease in symptom control, development of > 2 new symptoms, major treatment needed, visit to general practitioner required &/or admission to hospital necessary  
Major impact on welfare of patient [morbidity after visiting general practitioner, morbidity on discharge from hospital] and/or family  
Potential for major cost                                                                 |              |                     |
| □ 5   | Catastrophic | Death  
Catastrophic impact on welfare of family  
Major cost                                                                 |              |                     |

**Notes from Discussion between Expert Review Panel Members’ of their Individual & Consensus Assessments of Actual or Potential Consequence/Impact**
### b) Likelihood of Re-occurrence in Same or Other patients

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>Description- What is the likelihood of the scenario/event re-occurring? [for a different patient]</th>
<th>No of Votes</th>
<th>Consensus Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ A</td>
<td>Almost certain</td>
<td>Almost certain to re-occur in most circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ B</td>
<td>Likely</td>
<td>Likely to re-occur in most circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ C</td>
<td>Possible</td>
<td>Will possibly re-occur at some time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ D</td>
<td>Unlikely</td>
<td>Unlikely to re-occur at some time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ E</td>
<td>Rare</td>
<td>May rarely re-occur in exceptional circumstances</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes from Discussion between Expert Review Panel Members’ of their Individual & Consensus Assessments of Likelihood of Re-occurrence

### c) Classification of Risk (Likelihood of Re-occurrence x Actual or Potential Consequence/Impact)

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Individual Assessments</th>
<th>Consensus Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 No of Votes</td>
<td>2 No of Votes</td>
</tr>
<tr>
<td>A</td>
<td>H</td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>B</td>
<td>M</td>
<td></td>
<td>M</td>
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<tr>
<td>C</td>
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<td></td>
<td>M</td>
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<td>D</td>
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<tr>
<td>E</td>
<td>L</td>
<td></td>
<td>L</td>
</tr>
</tbody>
</table>

**Notes from Discussion between Expert Review Panel Members’ of their Individual & Consensus Assessments of Risk**

---

163
Appendix Z: Post-knowledge questionnaire

Pharmacists and Palliative Cancer Care Online Educational Program
Post-Knowledge Questionnaire

PLEASE DO NOT REMOVE THIS PAGE AS IT CONTAINS YOUR ID NUMBER

Insert ID Number: __________

Date: __________

As part of the evaluation of the study, pharmacists are required to complete a pre- and a post-knowledge questionnaire.

Now that the educational program phase of the study is finished, please complete this post-knowledge questionnaire. You may look up resources if you wish. It is anticipated that the questionnaire will take 30-45 minutes to complete.

Please return immediately – or, no later than 30th June 2005 – fax to Jill Beattie on 9903 9629.

If you have any questions, please contact Jill Beattie on: 0414 835 408

N.B. Results of this questionnaire along with the results of the pre-knowledge questionnaire will be provided as soon as all questionnaires have been returned and marked.

INSTRUCTIONS

The questionnaire contains 15 questions, for a total of 32 marks, with a mix of multiple-choice and short-answer questions.

Select the single best answer for multiple choice questions.
1. Nociceptive pain

   a) Is caused by injury to the nerve
   b) Occurs when there is stimulation of nerve endings
   c) Is characterised by pins and needles-type pain
   d) Is characterised by electric shock-like pain

2. A patient is using MS Contin 50mg oral BID and requiring 10mg Immediate Release morphine every 2 hours, on average. This regimen is causing significant nausea and vomiting. What would be an equivalent and appropriate dose of oxycodone?

   a. 110mg OXYCONTIN q12h
   b. 70mg OXYCONTIN q12h
   c. 50mg OXYCONTIN q12h
   d. 40mg OXYCONTIN q8h

3. Mrs BZ is a 72 year old woman with end-stage cancer of the breast. She is at home, and has severe pain. Currently she is receiving MS Contin 60 mg q12h and prn oral hydromorphone. The community palliative care nurse calls in to pick up the patient's medicines and tells you that she feels Mrs BZ needs parenteral opioids. She is unable to swallow medicines and has no intravenous access. Which of the following is the most appropriate route to recommend for opioid analgesic administration?

   a) Intramuscular
   b) Subcutaneous
   c) Intravenous via a PICC line catheter
   d) Intravenous via a peripheral intravenous catheter

4. Mr LV is a 67 year old man with prostate cancer. He has severe pain over his left hip and has been receiving the same dose of opioids for more than six months. During the last two weeks, the pain has worsened and increasing doses of opioid analgesics have been given. The pain is constant, aching and localised, without any referred pain. Increasing pain in Mr LV most likely represents:

   a) Worsening metastatic cancer
   b) Opioid addiction
   c) Opioid tolerance
   d) Opioid dependence

5. Intermittent bouts of sudden diarrhoea following constipation, with little warning of defaecation is most likely to be caused by which one of the following?

   a. Too much stimulant laxative
   b. Faecal impaction
   c. Too much stool softening laxative
   d. A malabsorption syndrome
6. Mr AS has recurring carcinoma of the tongue, which has spread to his lower jaw, despite chemotherapy and radiotherapy. His prognosis is poor, and treatment is now aimed at symptom management only. Mrs AS comes into your pharmacy very worried about Mr AS’s weight loss. He is that weak that she needs to “do everything for him”; he sleeps most of the day and won’t eat or drink. Mrs AS says “Do you think I should keep pushing him to eat?”

Which of the following would you advise?

a. Patients with cancer lose weight because they don’t get enough nutrition, yes, you should keep at him to take more
b. Not eating or drinking in cancer is caused by nausea and constipation, when we fix those he will eat more
c. This type of weight loss in cancer is related to local effects of the tumour and increased metabolic demands, therefore give him what he will tolerate
d. It is important to keep a record of what he eats and drinks so that the doctor can decide what best to feed him, so monitor him carefully

7. Three months after a patient’s death her husband comes to your pharmacy for something to help him sleep. He tells you that he sometimes thinks his wife is in the house talking to him, that he imagines he hears her voice, he has gained 10.5 kg since her death, but otherwise feels well. He says he thinks he is ‘going mad’, and asks you whether you think he should go to a psychiatrist. These symptoms are most consistent with a:

a) Complicated grief reaction
b) Major depression
c) Normal grief reaction
d) Post-traumatic stress disorder

8. Death from the side effects of using opioid analgesics, used with the intent to treat severe dyspnoea in a dying patient, is an example of:

a) Unprofessional practice
b) Double effect
c) Euthanasia
d) Physician-assisted suicide

9. Using medicines that are not marketed in Australia:

e) Is illegal
f) Requires the pharmacist to get the patient’s consent before dispensing
g) Requires no action other than dispensing of the prescribed medicine
h) Requires TGA approval

10. Information regarding the use of medicines, including complementary and alternative medicines (CAM), is changing all the time. The internet can be a valuable source of information about CAM. List 4 questions you need to ask yourself when searching web sites, to ensure that information is from reliable, evidence-based sources.
11. There are a number of emergencies that may occur in palliative care. List 4 palliative care emergencies in which the community pharmacist may play a role.

12. There are a number of incorrect assumptions (myths) surrounding the use of opioids for pain relief in palliative cancer care. List 5 of these incorrect assumptions.

13. Mrs RQ is a 35-year-old woman with metastatic breast cancer. She is married with a 5-year-old son. Her husband’s job often requires him to work away from home for extended periods of time; he is currently away. Mrs RQ comes into the pharmacy to fill her prescription for morphine; her pain is relieved by the morphine, she looks well, but tells you that she is feeling terrible. She tells you that she went for her 6-month check-up after her chemotherapy and radiotherapy, and the cancer has come back. She says that the doctors “can’t do anything for her; they’ve given me a couple of months to live”. Mrs RQ tells you that the cancer might have re-occurred because she is not a good mother; her son is often being looked after by relatives and friends. She keeps saying, “Why me? Why me?”

List 4 emotions that Mrs RQ is displaying.

14. The provision of palliative care services requires health care professionals to work together. List 3 activities that the community pharmacist can undertake to ensure the provision of high quality palliative care services.

15. Providing palliative care services can be stressful for health care professionals. There are a number of coping strategies that they can use to manage stress. List 3 coping strategies that are best avoided when attempting to manage stress associated with caring for palliative care patients/families.
Thank you
Please return your questionnaire in the Reply Paid envelope provided.
If the envelope has been mislaid, please forward to:

Safeera Hussainy  
Victorian College of Pharmacy  
Department of Pharmacy Practice  
381 Royal Parade  
Parkville, Victoria, 3052
Appendix AA: 3-month post-knowledge and post-program questionnaire

Pharmacists and Palliative Cancer Care Online Educational Program

Three-month Post-Knowledge Questionnaire

PLEASE DO NOT REMOVE THIS PAGE AS IT CONTAINS YOUR ID NUMBER

Insert ID Number: __________

Date: ________

As part of the evaluation of the study, pharmacists are required to complete a pre- and a post-knowledge questionnaire, and a 3-month knowledge questionnaire.

Now that the educational program phase of the study is finished, please complete this 3-month post-knowledge questionnaire. You may look up resources if you wish. It is anticipated that the questionnaire will take 30-45 minutes to complete.

Please return immediately – or, no later than 1st October 2005 - by post in the Reply Paid envelope provided, or fax to Jill Beattie, Pharmacy Practice on 03 9903 9629 (Include this page as it has your ID number).

If you have any questions, please contact Jill Beattie on: 0414 835 408

N.B. Results of this questionnaire along with the results of the previous questionnaires will be provided as soon as all questionnaires have been returned and marked.

______________________________

INSTRUCTIONS

The questionnaire contains 15 questions, for a total of 32 marks, with a mix of multiple-choice and short-answer questions.

Select the single best answer for multiple choice questions.
QUESTIONS

1. Nociceptive pain

   a) Is caused by injury to the nerve
   b) Occurs when there is stimulation of nerve endings
   c) Is characterised by pins and needles-type pain
   d) Is characterised by electric shock-like pain

2. A patient is using MS Contin 50mg oral BID and requiring 10mg Immediate Release morphine every 2 hours, on average. This regimen is causing significant nausea and vomiting. What would be an equivalent and appropriate dose of oxycodone?

   a. 110mg OXYCONTIN q12h
   b. 70mg OXYCONTIN q12h
   c. 50mg OXYCONTIN q12h
   d. 40mg OXYCONTIN q8h

3. Mrs BZ is a 72 year old woman with end-stage cancer of the breast. She is at home, and has severe pain. Currently she is receiving MS Contin 60 mg q12h and prn oral hydromorphone. The community palliative care nurse calls in to pick up the patient’s medicines and tells you that she feels Mrs BZ needs parenteral opioids. She is unable to swallow medicines and has no intravenous access. Which of the following is the most appropriate route to recommend for opioid analgesic administration?

   a) Intramuscular
   b) Subcutaneous
   c) Intravenous via a PICC line catheter
   d) Intravenous via a peripheral intravenous catheter

4. Mr LV is a 67 year old man with prostate cancer. He has severe pain over his left hip and has been receiving the same dose of opioids for more than six months. During the last two weeks, the pain has worsened and increasing doses of opioid analgesics have been given. The pain is constant, aching and localised, without any referred pain. Increasing pain in Mr LV most likely represents:

   a) Worsening metastatic cancer
   b) Opioid addiction
   c) Opioid tolerance
   d) Opioid dependence

5. Intermittent bouts of sudden diarrhoea following constipation, with little warning of defaecation is most likely to be caused by which one of the following?

   a. Too much stimulant laxative
   b. Faecal impaction
   c. Too much stool softening laxative
   d. A malabsorption syndrome
6. Mr AS has recurring carcinoma of the tongue, which has spread to his lower jaw, despite chemotherapy and radiotherapy. His prognosis is poor, and treatment is now aimed at symptom management only. Mrs AS comes into your pharmacy very worried about Mr AS’s weight loss. He is that weak that she needs to “do everything for him”; he sleeps most of the day and won’t eat or drink. Mrs AS says “Do you think I should keep pushing him to eat?”

Which of the following would you advise?

a. Patients with cancer lose weight because they don’t get enough nutrition, yes, you should keep at him to take more
b. Not eating or drinking in cancer is caused by nausea and constipation, when we fix those he will eat more
c. This type of weight loss in cancer is related to local effects of the tumour and increased metabolic demands, therefore give him what he will tolerate
d. It is important to keep a record of what he eats and drinks so that the doctor can decide what best to feed him, so monitor him carefully

7. Three months after a patient’s death her husband comes to your pharmacy for something to help him sleep. He tells you that he sometimes thinks his wife is in the house talking to him, that he imagines he hears her voice, he has gained 10.5 kg since her death, but otherwise feels well. He says he thinks he is ‘going mad’, and asks you whether you think he should go to a psychiatrist. These symptoms are most consistent with a:

a) Complicated grief reaction
b) Major depression
c) Normal grief reaction
d) Post-traumatic stress disorder

8. Death from the side effects of using opioid analgesics, used with the intent to treat severe dyspnoea in a dying patient, is an example of:

a) Unprofessional practice
b) Double effect
c) Euthanasia
d) Physician-assisted suicide

9. Using medicines that are not marketed in Australia:

a) Is illegal
b) Requires the pharmacist to get the patient’s consent before dispensing
c) Requires no action other than dispensing of the prescribed medicine
d) Requires TGA approval

10. Information regarding the use of medicines, including complementary and alternative medicines (CAM), is changing all the time. The internet can be a valuable source of information about CAM. List 4 questions you need to ask yourself when searching web sites, to ensure that information is from reliable, evidence-based sources.
11. There are a number of emergencies that may occur in palliative care. List 4 palliative care emergencies in which the community pharmacist may play a role.

12. There are a number of incorrect assumptions (myths) surrounding the use of opioids for pain relief in palliative cancer care. List 5 of these incorrect assumptions.

13. Mrs RQ is a 35-year-old woman with metastatic breast cancer. She is married with a 5-year-old son. Her husband’s job often requires him to work away from home for extended periods of time; he is currently away. Mrs RQ comes into the pharmacy to fill her prescription for morphine; her pain is relieved by the morphine, she looks well, but tells you that she is feeling terrible. She tells you that she went for her 6-month check-up after her chemotherapy and radiotherapy, and the cancer has come back. She says that the doctors “can’t do anything for her; they’ve given me a couple of months to live”. Mrs RQ tells you that the cancer might have re-occurred because she is not a good mother; her son is often being looked after by relatives and friends. She keeps saying, “Why me? Why me?”

List 4 emotions that Mrs RQ is displaying.

14. The provision of palliative care services requires health care professionals to work together. List 3 activities that the community pharmacist can undertake to ensure the provision of high quality palliative care services.
15. Providing palliative care services can be stressful for health care professionals. There are a number of coping strategies that they can use to manage stress. List 3 coping strategies that are **best avoided** when attempting to manage stress associated with caring for palliative care patients/families.

---

**You successfully completed the educational program 3 months ago.**

16. We are now interested in obtaining your **reflections** about the program and how it may have impacted on your pharmacy practice over the past 3 months.

Please write your comments in the space provided below. Areas you might wish to include may be whether you still use the program, whether it has improved your confidence in interacting with palliative care patients and what you liked or disliked about the program. If you have any other thoughts that you wish to share that would be very helpful.

---

Thank you

Please return your questionnaire in the Reply Paid envelope provided.

If the envelope has been mislaid, please forward to:

Safeera Hussainy  
Victorian College of Pharmacy  
Department of Pharmacy Practice  
381 Royal Parade  
Parkville, Victoria, 3052
Appendix AB: Post program evaluation questionnaire

N.B. This questionnaire was converted to an online format

Pharmacists and Palliative Cancer Care Online Educational Program
Program Evaluation Questionnaire

Information about this questionnaire
The purpose of this questionnaire is to obtain your opinion of the online educational program you have been working with. Your responses will be utilised to evaluate the program and make changes to improve the program for further use.

Key to answering the questions
A bar similar to that below is used throughout this questionnaire to enable you to indicate the extent to which you agree/disagree with the question statements. Please indicate the extent to which you agree or disagree with each statement by clicking ONE of the numbers (button) when the bars are provided.

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Additional comments
Please feel free to make additional comments in the spaces provided throughout this questionnaire.

Questions

1. Consider each of the statements and rate the extent to which you agree or disagree.

Following completion of the educational program:

   a) My level of knowledge related to palliative cancer care has increased.

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   b) I am better able to contribute to the management of palliative cancer care patients.

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   c) There has been an increase in the frequency of pharmacist-initiated changes in drug therapy for palliative cancer care patients.

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2. The subject material increased my understanding of the potential role of community pharmacists in palliative care.

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3. The subject material increased my understanding of the roles of other people involved in palliative care.

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4a. The website was easy to navigate.

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4b. Comments:

5a. The instructions contained within the program were adequate to direct my study of the subject material.

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5b. Comments:

6. The links were useful to assist my learning.

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7a. The links were distracting.

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7b. Comments:

8a. The subject material was generally new to me.

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8b. Comments:

9. The format of the subject material encouraged me to critically reflect upon what I was learning.

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10a. The format of the subject material encouraged me to analyse my own clinical practice.

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10b. Comments:

11. I used the Key Messages at the beginning of each Module to look for the topics I wanted to study.

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12. The Case Studies were useful in assisting my learning.

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13. The Activities in the program provided relevant learning experiences.

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Strongly disagree Strongly agree

14. The Activities and Answers to the Activities enabled me to monitor my progress in learning the subject material.

0 1 2 3 4 5 6 7 8 9 10
Strongly disagree Strongly agree

15. The Practice Points enabled me to learn the most important points for clinical practice.

0 1 2 3 4 5 6 7 8 9 10
Strongly disagree Strongly agree

16. The Notice Board helped me to compare my own knowledge of palliative cancer care with that of other pharmacists.

0 1 2 3 4 5 6 7 8 9 10
Strongly disagree Strongly agree

17a. The Discussion Group helped me to network with other pharmacists and specialists about palliative care issues.

0 1 2 3 4 5 6 7 8 9 10
Strongly disagree Strongly agree

17b. Comments:

18. The Discussion Group helped me to learn more about palliative cancer care.

0 1 2 3 4 5 6 7 8 9 10
Strongly disagree Strongly agree

19. I used the following resources whilst working with the program.

   a) Australian Medicines Handbook Yes No
   b) Therapeutic Guidelines Yes No
   c) Australian Prescription Products Guide (APP Guide) Yes No
   d) Other(s), please list in the space provided below
20. Rate the usefulness of each of the Modules.

a) Module 1: Getting the most from the program

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b) Module 2: Introduction – Principles of palliative cancer care

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c) Module 3: Management of cancer pain

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d) Module 4: Management of non-pain symptoms and side effects of treatment

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e) Module 5: Complementary and alternative medicines used by patients with cancer

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f) Module 6: Methods of medication administration

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g) Module 7: Access to palliative cancer care medicines

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h) Module 8: Psycho-social care

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i) Module 9: Communication with patients, carers and families

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j) Module 10: Ethical issues

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k) Module 11: Working in partnership to enhance patient care

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21. As a result of doing the program, I consulted/collaborated with the following people.

a) Other pharmacists

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b) General practitioners

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c) Nurses

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d) Patients’ hospital

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e) Patients

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f) Carers

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g) I consulted with no-one else

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h) Others (please write in the space provided below)

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22. How long did it take you to complete the program?

a) From 1 to 5 hours
b) From 6 to 10 hours
c) From 11 to 15 hours
d) From 16 to 20 hours
e) From 21 to 25 hours
f) From 26 to 30 hours
g) From 31 to 35 hours
h) From 36 to 40 hours
i) 41 hours or more

Overall:

23. The program could be improved by:
Comments:

24. I would recommend the program to other community pharmacists.

Yes No Undecided

25. Any other comments welcome

Thank you for taking the time to complete the questionnaire
Appendix AC: Patient/carer questionnaire

Interviewer administered Questionnaire for Mercy Western Palliative Care patients or their carer: Assessment of medication knowledge, recall of medical information and interaction with the pharmacist

Hello my name is __________. Thank you for taking the time to answer some questions about your/the patient’s medications.

This information will help us to evaluate the study, “Improving medication management of palliative care patients: enhancing the role of community pharmacists.”

Your responses will remain anonymous.

Safeera Hussainy
Victorian College of Pharmacy
Department of Pharmacy Practice
381 Royal Parade
SECTION 1: DEMOGRAPHICS

Identify who will be completing the questionnaire

1. Person completing the questionnaire
   □ Patient
   □ Legal carer ¹

To begin with, I’ll ask you some general questions.

2. Are you responsible for managing your/the patient’s medications at home?
   □ Patient
   □ Legal carer

3. What is your age?
   □ 21-29 years
   □ 30-39 years
   □ 40-49 years
   □ 50-59 years
   □ 60 years and over

4. Gender of the person responding to the questionnaire
   □ Male
   □ Female

¹ Legal Carer /The carer may be a health service provider/family member/friend who has legal authority on behalf of the patient, and has the responsibility of managing the patient’s medications and interacting with the pharmacist/
SECTION 2: ASSESSMENT OF MEDICATION KNOWLEDGE AND
RECALL OF MEDICAL INFORMATION

5. What medications do you/does the patient currently take?

[Ask the patient/legal carer about the medications first, then request they show you the medications that they/the patient is currently taking, so that you can then decide if their answers were correct or incorrect according to the instructions on the medication label. Remember to request the patient/legal carer to show you both prescription and over-the-counter (OTC) medications]

[This table contains information to be provided by the patient/legal carer and is for note-taking by the researcher to gain information for answering question 5]

<table>
<thead>
<tr>
<th>Medication name (Brand/Generic)</th>
<th>What is this medication for?</th>
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6. a) Have you/the patient ever experienced any unwanted effects from the medications you/the patient is currently taking? [Only give example if can’t recall e.g. constipation.]
   □ Yes [go to question 6b]
   □ No [go to question 7]

b) If yes, what are the unwanted effects that you/the patient has experienced?

[This table contains information to be provided by the patient/legal carer and is for note-taking by the researcher to gain information for answering question 6b].

<table>
<thead>
<tr>
<th>Unwanted effect</th>
<th>Did you contact the pharmacist for advice?</th>
<th>Was the advice provided by the pharmacist useful?</th>
<th>What was the advice? [e.g. referral to the doctor]</th>
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<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Can’t remember</td>
<td>□ Yes □ No</td>
<td>□ Undecided</td>
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7. a) Do you/the patient use any of the following devices to help manage your/the patient’s medications?
   □ Dosette
   □ Syringe driver
   □ Other __________________________
   □ Doesn’t use devices to help manage medications

b) Who recommended the device(s) to you/the patient?
   □ Pharmacist
   □ GP
   □ Palliative care doctor
   □ Nurse
   □ Legal carer
   □ Friend
   □ Family member
   □ Alternative health care practitioner. Please state __________________________
   □ Other __________________________
   □ No one
   □ Can’t remember
8. a) Can you recall any change made to your/the patient’s medication in the last 3 months? [Wait for an answer before giving an example e.g. change of pain killer, increase/decrease of the dose of a medicine]
   □ Yes [go to question 8b & c]
   □ No  [go to question 9]

b) If yes, who made the change?
   □ Pharmacist
   □ GP
   □ Palliative care doctor
   □ Nurse
   □ Legal carer
   □ Friend
   □ Family member
   □ Alternative health care practitioner. Please state ______________________
   □ Other ______________________
   □ Self
   □ Can’t remember

c) What was the change?
   □ Stopping a medication
   □ Stopping a medication and starting another one
   □ Starting another medication
   □ Decreasing the dose of a medication
   □ Increasing the dose of a medication
   □ Other ______________________
   □ Can’t remember

9
a) There are times when people do not take medications that the doctor orders. In the last 3 months, have you/the patient, not taken a medication prescribed for you/the patient?
   □ Yes [go to question 9b]
   □ No  [go to question 10]
b) If yes, for what reason(s) did you/the patient not take the medication? [Wait for their answers before giving an example eg unwanted effects]

- Unwanted effects
- Taking too many medications already
- Didn’t know why I needed to take it
- Didn’t think I needed it
- Didn’t know how to use it properly
- Forgot to take it
- Other

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c) Did you/the patient consult anyone regarding the decision not to take the medications?

- Yes [go to question 9d]
- No [go to question 9c]

d) If yes, who did you/the patient consult?

- Pharmacist
- GP
- Palliative care doctor
- Nurse
- Carer
- Friend
- Family member
- Alternative health care practitioner. Please state ______________________
- Other ______________________
- Can’t remember

e) If no, can you tell me why you/the patient didn’t consult anyone?

- Didn’t think it was important to
- Didn’t want to trouble anyone
- Other ______________________
SECTION 3: ASSESSMENT OF INTERACTION WITH THE PHARMACIST

10. How many pharmacies do you/the patient visit to obtain medications/products?
   □ One
   □ Two
   □ More than two
   □ Can’t remember

11. In general, how do you find your interaction with the pharmacist has been?

SHOW CARD 1

<table>
<thead>
<tr>
<th>Interaction with Pharmacist</th>
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12. In general, what kind of information was given by the pharmacist with respect to managing your/the patient’s medications? [Wait for their answers before giving any examples- eg explanation about your medicines]
   □ Information on your/the patient’s condition & its treatments
   □ Explanation of medications (names/uses/doses/how to use them)
   □ Communication with other health professionals regarding your/the patient’s condition and/or medication management
   □ Information on ways to treat symptoms without using medications e.g. relaxation techniques for pain
   □ Information on support groups/useful internet sites/hotlines etc.
   □ Management of the costs of medications
   □ Other

13. How did the pharmacist provide the information to you?
   □ Verbal
   □ Written
   □ Combination of both

14. In general, how valuable is the information given by the pharmacist?

SHOW CARD 2

<table>
<thead>
<tr>
<th>Value of information from Pharmacist</th>
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<td>Very poor</td>
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15. a) In general, has the pharmacist helped you/the patient to improve your/their quality of life?
   - ☐ Yes [go to question 15b]
   - ☐ No  [please comment, then go to question 16]
   - ☐ Don’t know [please comment, then go to question 16]

b) If yes, in what ways?
   - ☐ Better symptom control
   - ☐ Less unwanted effects
   - ☐ Takes the time to answer my questions
   - ☐ Supplies medications when I/the patient need them
   - ☐ Delivers medication to my/the patient’ home
   - ☐ Other

16. What could the pharmacist do to improve their interaction with you?

17. We would welcome anything else you can tell us.

Thank you very much for your co-operation and contribution
Appendix AD: Letter of Invitation (Evaluation Group pharmacists)

MONASH University

Invitation to participate in research: Evaluation group Pharmacists

As a community pharmacy located in western metropolitan Melbourne, you are invited to participate in the evaluation of an educational program in palliative cancer care. This is an innovative educational program developed specially for community pharmacists. We seek up to two pharmacists from your pharmacy, working greater than 20 hours per week, for participation in the project.

The attached Explanatory Statement explains what is involved in this research project.

If you wish to be involved or have any questions concerning this project please contact:

Safeera Hussainy on (03) 9903 9025 or
Jill Beattie on (03) 9903 9080
at the Victorian College of Pharmacy
Appendix AE: Explanatory Statement (Evaluation Group pharmacists)

Explanatory Statement: Evaluation Group Pharmacists

Date:

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

About the Explanatory Statement

This Explanatory Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please read this Explanatory Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative, friend or colleague. Feel free to do this. Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project. You will be given a copy of the Explanatory Statement and Consent Form to keep as a record.

The Aim of the Research Project

The Pharmacy Guild of Australia is funding research to develop, implement and evaluate an educational program for community pharmacists in palliative care. The major aims of the program are to increase the knowledge and skills of pharmacists in the delivery of effective palliative care, and as a result, improve medication knowledge of palliative care patients, with consequent reduction in health costs such as hospitalisations due to medication errors. My name is Safeera Hussainy, and I will be doing this research as a PhD candidate under the supervision of: Prof Roger Nation, Dr Jennifer Marriott and Mr Michael Dooley who are from the Department of Pharmacy Practice, Victorian College of Pharmacy, Monash University.

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of this Institution.

Palliative care relates to the care of patients who have a progressive life-threatening illness. Approximately 70 to 80% of patients receiving palliative care are at home, and most receive ongoing prescription and over-the-counter medication from their community pharmacist. Many community pharmacists, however, may not have the knowledge, skills and confidence to contribute effectively to the delivery of palliative care services to people living in the community. If given adequate education and training, community pharmacists are in an ideal position to offer an increased range of services.
Appendix AE

Why You Are Being Invited to Participate
An educational program in palliative cancer care is being developed for community pharmacists. This educational program will be trialled and evaluated by recruiting approximately 30 to 60 community pharmacists from western metropolitan Melbourne. Pharmacists will be allocated to either a test group or control group.

Pharmacists from the test group will undertake the educational program. Pharmacists from the control group will not undertake the program, but will provide their ‘standard’ level of care to patients. They will have access, however, to the educational program, after completion of the project.

The primary method of delivery of the educational program will be via the web, with paper-based support. Emphasis will be upon problem-based learning that facilitates translation of the factual material into a practice context and builds the confidence of pharmacists in applying their newly acquired knowledge. A ‘discussion’ group will be established at the website to encourage networking among participating pharmacists (to share experiences, problems and solutions) and to provide a mechanism for feedback from palliative care specialists. The discussion group will be monitored and moderated by Peter MacCallum Cancer Institute, Victoria, Australia.

What does participation involve?
Both groups of pharmacists will be involved in the implementation trial. This trial involves pharmacists documenting their healthcare interventions with patients recruited from Mercy Western Palliative Care in Melbourne. These interventions will be recorded, commencing one month prior to the test group of pharmacists starting the educational program, and continue throughout the program, until one month after the test group completes the educational program.

Both groups of pharmacists will also be asked to complete a multi-choice, problem-based questionnaire designed to assess their knowledge and skills in palliative cancer care. If you are in the test group, this will be before, immediately after, and four months after, completion of the educational program. If you are in the control group, this will be before, immediately after, and four months after the test group undertakes the educational program. It will take approximately 1 hour to complete this questionnaire.

A letter of invitation will be sent to pharmacies in western metropolitan Melbourne who see patients from Mercy Western Palliative Care. The first thirty pharmacies to accept will be randomly allocated to either the test or control group. Pharmacists who are involved in this project must work more than twenty hours per week in one of these community pharmacies. You may contact the research project team to accept or decline participation in the project. Participation is voluntary. Your personal information will be identified by a code number so you remain anonymous.

Our team anticipates that you will have approximately two Mercy Western Palliative Care patients under your care during the implementation trial. You will be trained by our research project team to record interventions Interventions will be reviewed by an Expert Review Panel, comprising a pharmacist, general practitioner, nurse and physician, all with experience in palliative care. This would include assessment of the projected impact on use of resources such as medications, consultations and potential hospitalisation. Time required to record interventions is estimated to be 30 minutes per day.

If you are a pharmacist allocated to the test group, being part of this project also involves undertaking an educational program, which will take approximately 20 hours over three months, including a questionnaire on completion and again at 4 months to assess satisfaction with the program.
Your Anonymity
No findings which could identify you as an individual participant will be published. Only the combined results of participants will be published. You may contact the research project team if you would like a copy of the results. Only the researchers will have access to the original data, which will be retained in the Department of Pharmacy Practice for no longer than five years after completion of the project. After this, the data will be disposed of by shredding.

You will not be paid for your participation in this project. For those pharmacists who complete the educational program, either as part of this study, or by accessing it after the study, you may be awarded with continuing pharmacist education (CPE) points.

Questions
If you have any questions or would like to be informed of the research findings, please contact: 9903 9025 (telephone) or 9903 9629 (fax).

Complaints
Should you have any complaint concerning the manner in which this research (Project number: 2003/834MC and R03/48H) is conducted, please do not hesitate to contact the research Committees below.

The Secretary
The Standing Committee on Ethics in Research Involving Humans
PO Box No 3A
Monash University
Victoria 3800
Telephone +61 3 9905 2052
Fax +61 3 9905 1420
E-mail: SCERH@adm.monash.edu.au
Project Number: 2003/834MC

Vicky Karitinos
Secretary of the Research Ethics Committee, Mercy Health and Aged Care
C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: VKaritinos@mercy.com.au
Project Number: R03/48H

Thank you.

Safeera Hussainy
PhD Scholar.
9903 9025
Appendix AF: Informed Consent (Evaluation Group pharmacists)

Informed Consent Form for Evaluation group Pharmacists

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

I agree to take part in the above Monash University research project. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that I am willing to:

Test group
- Be a recipient of the educational program.
- Complete a questionnaire immediately after, and 4 months later, after completion of the educational program, to assess satisfaction with the program.

Test and Control groups
- Complete a questionnaire to assess my knowledge and skills of palliative care before, immediately after and 4 months later after the test group completes the educational program.
- Participate in the implementation trial for an assigned period of time.
- Allow the researchers to collect and record my personal information.

I understand that any information I provide is confidential, and that no information that could lead to my identification will be disclosed in any reports on the project, or to any other party.

I also understand that my participation is voluntary and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

If you require further information, or if you have any questions about this project, please contact Safeera Hussainy on 9903 9025 or Jill Beattie on 9903 9080.

Should you have any complaint concerning the manner in which this research (Project number: 2003/834MC and R03/48H) is conducted, please do not hesitate to contact the research Committees below.

The Secretary
The Standing Committee on Ethics in Research Involving Humans
PO Box No 3A
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Telephone +61 3 9905 2052
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C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: VKaritinos@mercy.com.au
Project Number: R03/48H

Thankyou.

______________ (Your signature)

______________ (Your printed name)

______________ (Date)
Appendix AG: Revocation of Consent form (Evaluation Group pharmacists)

Revocation of Informed Consent Form: Evaluation Group Pharmacists

Project Title: Improving medication management of palliative care patients: enhancing the role of community pharmacists.

I hereby wish to WITHDRAW my consent to participate in the research project described above and understand that such withdrawal WILL NOT jeopardise my relationship with Monash University or any healthcare team member.

If you require further information, or if you have any questions about this project, please contact Safeera Hussainy on 9903 9507 or Jill Beattie on 9903 9080.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact either:

The Secretary
The Standing Committee on Ethics in Research Involving Humans
PO Box No 3A
Monash University
Victoria 3800
Telephone +61 3 9905 2052
Fax +61 3 9905 1420
E-mail: SCERHadm.monash.edu.au
Project Number: 2003/834MC

Vicky Karitinos
Secretary of the Research Ethics Committee, Mercy Health and Aged Care
C/o Mercy Hospital for Women
126 Clarendon Street
East Melbourne 3022
Telephone +61 3 9270 2837
E-mail: VKaritinos@mercy.com.au
Project Number: R03/48H

Thankyou.

_________________________________(Your signature)
_________________________________(Your printed name)
_________________________________(Date)
Appendix AH: Major changes made to original D.O.C.U.M.E.N.T. tool

1. Length of tool shortened considerably so that it’s more user-friendly and pharmacists can complete it with ease immediately after an intervention has been made.
2. Sub-categories added or eliminated to some of the eight drug-therapy problem categories:
   ‘Over or under dose prescribed’: ‘Incorrect duration’ added and category re-named to ‘Over or underdose, frequency and duration’.
   ‘Untreated indications’: ‘Condition not treated adequately’ added (after piloting).
   ‘Education or Information’: ‘Patient drug information requests’, ‘Demonstration of device’ and ‘Disease management or advice’ eliminated.
   ‘Confusion about therapy or condition’ re-named to ‘Lack of knowledge/confusion about condition’ and ‘Lack of knowledge/confusion about therapy’.
   ‘Non-clinical’:
   Definition of a non-clinical intervention included.
   ‘Toxicity or Adverse Reaction’:
   Caused by dose too high’ and ‘Caused by drug interaction’ eliminated.
   ‘Brief Description of Event’, ‘Severity and Duration,’ and ‘Possible Cause’ added.
3. ‘Description of Drug-Therapy Problem’ added for each drug-therapy problem category.
4. ‘Recommendations to Resolve the Problem’ added for each drug-therapy problem, rather than being one separate section/question.
5. ‘Description of Recommendation’ added for each drug-therapy problem.
6. Time taken to perform actions to investigate and resolve the problem added for each action, rather than being one, separate section/question.
7. ‘Clinical Significance of the Problem’ eliminated because the significance of the intervention would be assessed by the Expert Review Panel (Refer to Sections 3.3.4.6 & 3.3.4.8 below), rather than the pharmacist who made the intervention.
8. ‘Other Information Regarding the Problem’ eliminated because 4) and 5) were added.
9. Demographic information included (‘Today’s Date’, ‘Patient’s/Carer’s Code Number’, ‘Pharmacist’s Initials’).

(Peterson et al., 2003)
Appendix Al: Marking guide – Pre-knowledge questionnaire

Pharmacists and Palliative Cancer Care Online Educational Program
Pre-Knowledge Questionnaire

ANSWER SHEET

QUESTIONS AND ANSWERS

INSTRUCTIONS

The questionnaire contains 20 questions, with a mix of multiple-choice and short-answer questions.

Select the single best answer for multiple choice questions.

1. The most important additional therapy to consider when starting a patient on opioids for pain is:
   a) Amphetamines to increase alertness
   b) Antidepressants as an adjuvant for pain relief
   c) Laxatives to prevent constipation
   d) Non-steroids (NSAIDs) to treat inflammation

   Correct answer – c) [Module 4]

2. Neuropathic pain is often characterised by:
   a) Dull achy pain
   b) Colicky pain
   c) Low-grade gnawing pain
   d) Electric Shock-like pain

   Correct answer – d) [Module 3]

3. A patient is taking an oxycodone immediate release tablet 5 mg (Endone), 4 times a day. What is the equivalent dose of a long-acting morphine preparation?
   a. 15 mg q12h
   b. 15 mg q8h
   c. 30 mg q12h
   d. 30 mg q8h

   Correct answer – a) [Module 3]
4. Mrs BZ is a 72 year old woman with end-stage cancer of the breast. She is at home, and has severe pain. Currently she is receiving MC Contin 60 mg q12h and prn oral hydromorphone. The community palliative care nurse calls in to pick up the patient’s medicines and tells you that she feels Mrs BZ she needs parenteral opioids. She is unable to swallow medicines and has no intravenous access. Which of the following is the most appropriate route to recommend for opioid analgesic administration?

   a) Intramuscular
   b) Subcutaneous
   c) Intravenous via a PICC line catheter
   d) Intravenous via a peripheral intravenous catheter

   Correct answer – b) [Module 6]

5. Mr LV is a 67 year old man with prostate cancer. He has severe pain over his left hip and has been receiving the same dose of opioids for more than six months. During the last two weeks, the pain has worsened and increasing doses of opioid analgesics has been given. The pain is constant, aching and localised, without any referred pain. Increasing pain in Mr LV most likely represents:

   a) Worsening metastatic cancer
   b) Opioid addiction
   c) Opioid tolerance
   d) Opioid dependence

   Correct answer – a) [Module 3]

6. Mrs KO is a 45 year old woman has metastatic carcinoma of the breast, with bone, lung and liver secondaries. Her husband comes into the pharmacy to fill a prescription for morphine. He tells you that he is extremely concerned because Mrs KO is very nauseous. He asks you for something for the nausea. Before you can advise Mr KO, list 4 questions you would ask Mr KO in determining the best option for his nausea.

   **Answers**

   Onset [when did it first start]
   The intensity of the nausea
   Frequency
   Duration
   Aggravating factors eg vomiting, constipation, chemo, radiotherapy, other drugs, allergies
   Alleviating/relieving factors eg vomiting,
   Has she taken antiemetics before?
   Have they told Dr?
   Can she swallow tablets?
   Does she mind if meds make her drowsy?
   Can she tolerate injectable antiemetics?
   NB – to get a mark, questions need to be clear and specific – vague or ambiguous answers not accepted

   **Not accepted:**

   Is she on anything else for nausea, [as her husband is asking for something for the nausea – this will also be found out if ask for on other drugs]
   Dose of morphine and tolerance not relevant, nor has she been on morphine before
How much does she weigh? [those areas above are considered more relevant to determining best option for relieving the nausea

[One mark for each point – up to 4 marks] [Module 4]

7. Mrs SC has just been prescribed morphine (controlled-release oral preparation) for the first time for cancer-associated pain. Which of the following would be the most appropriate approach to the management of possible opioid-induced constipation:

   a. If constipation occurs after commencing morphine, introduce a fibre-based laxative
   b. Commence a stimulant laxative such as senna at the same time as the morphine
   c. If constipation occurs after commencing morphine, introduce a stimulant laxative such as senna
   d. Commence a stool softening agent combined with a bowel stimulant at the same time as the morphine

Correct answer is d) [Module 4]

8. Miss BT, who has advanced cancer, has been having increasing difficulty with a dry mouth. Which of the following is least appropriate advice for management of this symptom?

   a. Regular rinsing with an antiseptic gargle
   b. Taking of frequent sips of water and/or sucking on ice chips
   c. Regular rinsing with water or normal saline
   d. Using chewing gum

Correct answer is a) [Module 4]

9. Intermittent bouts of sudden diarrhoea following constipation, with little warning of defecation, is most likely to be caused by which one of the following?

   a. Too much stimulant laxative
   b. Faecal impaction
   c. Too much stool softening laxative
   d. A malabsorption syndrome

Correct answer is b) [Module 4]

10. Mr AS has recurring carcinoma of the tongue, which has spread to his lower jaw, despite chemotherapy and radiotherapy. His prognosis is poor, and treatment is now aimed at symptom management only. Mrs AS comes into your pharmacy very worried about Mr AS’s weight loss. He is that weak that she needs to “do everything for him”; he sleeps most of the day and won’t eat or drink. Mrs AS says “Do you think I should keep pushing him to eat?”

Which of the following would you advise?

   a. Patients with cancer lose weight because they don’t get enough nutrition, yes, you should keep at him to take more
   b. Not eating or drinking in cancer is caused by nausea and constipation, when we fix those he will eat more
   c. This type of weight loss in cancer is related to local effects of the tumour and increased metabolic demands, therefore give him what he will tolerate
   d. It is important to keep a record of what he eats and drinks, so that the doctor can decide what best to feed him, so monitor him carefully

Correct answer – c) [Module 4]
11. Three months after a patient’s death her husband comes to your pharmacy for something to help him sleep. He tells you that he sometimes thinks his wife is in the house talking to him, that he imagines he hears her voice, he has gained 10.5 kg since her death, but otherwise feels well. He says he thinks he is ‘going mad’, and asks you whether you think he should go to a psychiatrist. These symptoms are most consistent with a:

   a) Complicated grief reaction
   b) Major depression
   c) Normal grief reaction
   d) Post-traumatic stress disorder
   Correct answer – c) [Module 8]

12. Death from the side effects of using opioid analgesics, that used with the intent to treat severe dyspnoea in a dying patient, is an example of:

   a) Unprofessional practice
   b) **Double effect**
   c) Euthanasia
   d) Physician-assisted suicide
   Correct answer – b) [Module - 10]

13. Off-label medicines are:

   a. Also known as ‘orphan’ drugs
   b. **Used outside the TGA approved indications**
   c. Illegal for pharmacists to dispense
   d. Rarely used in palliative care and cancer treatment
   Correct answer – b) [Module 7]

14. Mrs UL comes into your pharmacy to fill a prescription for her husband for prednisolone, augmentin, naproxen, cyclosporine and morphine. Mr UL is 54 years old and has been diagnosed with inoperable and incurable lung cancer. Mrs UL tells you that the GP thinks Mr UL shows some signs of depression, but not enough to diagnose a formal major depression - the GP thinks that Mr UL’s change in mood could be due to depression, medications (e.g. steroids and chemotherapy) and/or cerebral metastases. Mr UL does not want to take any more pharmaceutical medicines but is open to looking at complementary and alternative medicine (CAM) treatments. Mrs UL says that she has read that St John’s Wort is good for depression.

What do you advise about the suitability of St John’s Wort for Mr UL?

   a. St John’s Wort is safe and can be used for Mr UL
   b. St John’s Wort can be commenced to see how Mr UL responds to it
   c. **St John’s Wort interacts with numerous other medicines and is relatively contraindicated for Mr UL**
   d. St John’s Wort has been proven to be more effective than other antidepressants
   Correct answer – c) [Module 5]
15. When a palliative care patient or their carer tells you that they are taking herbal medicines, which of the following questions is least important to ask?

a) What medicines are they taking?
b) **How much do they cost?**
c) What are they taking the medicines for?
d) Are they allergic to any plant products?

Correct answer – b) [Module 5]

16. Suffering encompasses more than physical pain, list 3 other areas that may cause suffering in the patient receiving palliative cancer care.

**Answers**

Spiritual concerns eg related to death/dying, guilt, despair, depression, fear, dignity
Social difficulties eg financial, isolation, loneliness
Cultural issues eg grief, loss, worry about family,
Psychological problems eg anger, anxiety, low self-esteem, lethargy (lack of motivation), loss of independence, quality of life

NB – it is difficult to separate each of these and their causes etc – eg depression, loneliness, fear, loss of independence etc - may fit into each category – but only one mark would be given.

NB – to get a mark, answers need to be clear and specific – vague or ambiguous answers not accepted

[one mark for each point – up to 3 marks] [Module 2]

17. Surveys indicate that less than 50% of palliative care patients with cancer receive adequate pain relief. A number of barriers to the provision of effective pain relief have been found to be related to healthcare professionals - list 3 such barriers.

**Answers**

Poor knowledge of pain relief strategies
Adherence to opioid myths
Low expectation of relief
Poor attitude – lack of compassion or involvement, denial of pain, not listening to the patient, not spending time educating/counselling the patient
[legal] Lack of knowledge of legislative requirements and misinterpreting regulation
Access to medicines and health care professionals
Lack of communication between health professionals [between health care professionals needs to be stated]

NB – to get a mark, answers need to be clear and specific – vague or ambiguous answers not accepted

**Not accepted:**
Statements related to patients eg being able to communicate with Dr.
Disease-related eg unstable, co-morbidities
Drug-related eg adverse effects, cost

[one mark for each point – up to 3 marks] [Module 3]
18. It is often very difficult to communicate effectively with palliative care patients or their carers when they come to your pharmacy to fill prescriptions. Which of the following is least important consideration if you are to communicate effectively with these customers when they come into your pharmacy?

a) Allocation of a hour time-slot  
  b) A quiet place to sit  
  c) A welcoming smile  
  d) A show of empathy  
Correct answer – a) [Module 9]

19. When reviewing medicines of palliative care patients, there are a number of known factors that predispose the patient to medication-related adverse events. List 4 risks factors that predispose patients to medication-related adverse events.

**Answers**
- Taking 5 or more regular medicines [polypharmacy accepted]
- Taking more than 12 doses of medicines per day – incorrect dosing – accepted [if state ‘doses’ only – no mark]  
- Significant changes [to meds] made to medication treatment regimen in the last 3 months  
- Taking medicines with a narrow therapeutic index  
- Taking medicines that require therapeutic monitoring [one mark only if state poor renal/liver/neuro etc function]  
- Experiencing symptoms suggestive of an adverse drug reaction [if put a list of symptoms – only marked as one point]  
- Experiencing sub-therapeutic response to treatment with medicines  
- Suspected non-compliance or inability to manage medication-related therapeutic devices  
- Having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties [if put a list of these difficulties – only marked as one point]
- Attending a number of different doctors, both general practitioners and specialists  
- Recent admission to a facility/hospital (in the last 4 weeks)  
- Elderly [but no marks for only stating age]

NB – to get a mark, answers need to be clear and specific – vague or ambiguous answers not accepted

**Not accepted:**
- Lack of knowledge  
- Disease states eg diabetes etc – as fits in with polypharmacy  
  [one mark for each point – up to 4 marks] [Module 11]

20. Spinal cord compression secondary to metastatic disease is potentially devastating. It can result in paraplegia; however, early signs may be detected. List 3 signs and symptoms that may alert you to a patient presenting with impending spinal cord compression.

**Answers**
- Any back pain that radiates around to the front of the chest of abdomen (Gradual onset of localised back pain, which progresses)  
- Pain that suddenly changes in character  
- Numbness or weakness - tingling [one mark only]  
- Pain that increases with straight leg raising  
- Motor weakness and sensory loss  
- Hesitancy when voiding [probs] and incomplete emptying of the bladder, leading to urinary retention and overflow  
- Constipation  
  [one mark for each point – up to 3 marks] [Module 4]
## Appendix AJ: Post-program Evaluation questionnaire: Additional comments

<table>
<thead>
<tr>
<th>ID</th>
<th>user_id</th>
<th>Question 4b: The website was easy to navigate.</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>E1001an</td>
<td>I found the course material very informative and challenging. The biggest and most annoying problem was that on my computer, neither the side bars nor the content were fully visible without continual scrolling from side to side...this wasted untold time and sent me crazy. Otherwise thanks to the people who thought up the idea and put it into practice.</td>
</tr>
<tr>
<td>43</td>
<td>E1002rb</td>
<td>I couldn't open/close the left hand column displaying the modules. It was a bit difficult reading the information on a small page.</td>
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<tr>
<td>12</td>
<td>E1003ym</td>
<td>Not easy really but it got better with practise</td>
</tr>
<tr>
<td>34</td>
<td>E1004ok</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td>for someone who has not used the internet often it was very user friendly, easy to follow &amp; understand</td>
</tr>
<tr>
<td>29</td>
<td>E1008as</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>E1009er</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>E1010mw</td>
<td>The programme was interesting, but added little to my current practice. I feel that the programme was not that well directed to most community pharmacists.</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>For someone who has never really used the internet it has shown me a new world of information. Very helpful but very time consuming.</td>
</tr>
<tr>
<td>39</td>
<td>E1012yh</td>
<td>I think I would have benefited from a greater number of on line activities-maybe double the number we completed in this program.</td>
</tr>
<tr>
<td>30</td>
<td>E1013vo</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>E1014th</td>
<td>I found I could not access the correct site to be involved in question 1C. I did post some comments on the discussion group and probably need to do more to get a better use of this system.</td>
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<tr>
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<td>E1017je</td>
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<tr>
<td>8</td>
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<td>33</td>
<td>E1023mn</td>
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<tr>
<td>14</td>
<td>E1026de</td>
<td>unable to access program tree</td>
</tr>
<tr>
<td>28</td>
<td>E1028jh</td>
<td>Once we upgraded to broadband it was easy - dial-up was slow with regular dropouts</td>
</tr>
<tr>
<td>19</td>
<td>E1031ki</td>
<td>I enjoyed the program for the information I obtained. Navigating the net was fairly simple but at times it just did not happen or was extremely slow (may be my server). Some cross checking between modules was a bit tedious. Overall I thoroughly enjoyed the program.</td>
</tr>
<tr>
<td>7</td>
<td>E1033yt</td>
<td>I used the cd provided a fair bit because I took it with me to work etc and didn't always have access to internet. This worked pretty well</td>
</tr>
<tr>
<td>22</td>
<td>E1034iy</td>
<td>I have the best way was to start at the beginning and just work my way through it</td>
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<tr>
<td>15</td>
<td>E1035uy</td>
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<td>E1037bi</td>
<td>Needed more info or would have liked to know about the roles of other palliative care health professionals</td>
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<td>some of reference sites would freeze computer</td>
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<tr>
<td>31</td>
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<td>very straightforward layout</td>
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<tr>
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Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

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<th>ID</th>
<th>user_id</th>
<th>Question 5b: The instructions contained within the program were adequate to direct my study of the subject material.</th>
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</thead>
<tbody>
<tr>
<td>23</td>
<td>E1070fp</td>
<td>For someone who has not done this before, the first couple of modules were hard to navigate. Got a better grasp after that. With a 17 inch computer screen at work, the whole page was not presented. Had to move page right and left most of the time.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>yes it was easy to navigate through the website. the only problem I had was logging on to discussion group but this was resolved.</td>
</tr>
<tr>
<td>35</td>
<td>i1054zz</td>
<td>Information was very interesting and useful! Everyone should learn it at uni!</td>
</tr>
<tr>
<td>10</td>
<td>i1060ks</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>i1061nw</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>E1070fp</td>
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<tr>
<td>38</td>
<td>i1067om</td>
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<th>user_id</th>
<th>Question 5b: The instructions contained within the program were adequate to direct my study of the subject material.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>E1001an</td>
<td>I had a few mistakes trying to use the forum and answering the questions/activities by entering an unfinished answer</td>
</tr>
<tr>
<td>43</td>
<td>E1002rb</td>
<td>I found the instructions very easy to follow &amp; very clear</td>
</tr>
<tr>
<td>12</td>
<td>E1003ym</td>
<td>Excellent format, easy to follow, and prompted further investigation/web searches.</td>
</tr>
<tr>
<td>34</td>
<td>E1004ok</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td></td>
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<td>29</td>
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<tr>
<td>4</td>
<td>E1011wa</td>
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<tr>
<td>19</td>
<td>E1031ki</td>
<td>Sent off and recvd a number of references publications. It seems that people/associations connected with PC (esp cancer) are very sympathetic and co-operative.</td>
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<tr>
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<td>I enjoyed re learning a lot of the different contents of each module</td>
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<td>Initially found noticeboard hard to access but sorted it out.</td>
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### Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

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<th>Question 7b: 7a. The links were distracting.</th>
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<tr>
<td>12</td>
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<td>great resources discovered - Thankyou</td>
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<td>E1004ok</td>
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<tr>
<td>36</td>
<td>E1007pc</td>
<td>the links were great, allowing extra study &amp; knowledge</td>
</tr>
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<td>E1008as</td>
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</tr>
<tr>
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<td>E1009er</td>
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<td>32</td>
<td>E1010mw</td>
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</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>I think the links were extremely useful, Although time consuming they provided an education in themselves &amp; could be useful resources for myself &amp; for my clients.</td>
</tr>
<tr>
<td>39</td>
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</tr>
<tr>
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<td>8</td>
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<tr>
<td>33</td>
<td>E1023mn</td>
<td>Links were good, when you were on the net version. on the CD it was a little more frustrating as you couldn't go to the link straight away.</td>
</tr>
<tr>
<td>14</td>
<td>E1026de</td>
<td></td>
</tr>
<tr>
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<td>E1028jh</td>
<td>Used some links as a printout ready to give to customers.</td>
</tr>
<tr>
<td>19</td>
<td>E1031kl</td>
<td>When necessary the links were very helpful although there were many</td>
</tr>
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<td>Links were repetitive</td>
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<tr>
<td>15</td>
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</tr>
<tr>
<td>42</td>
<td>E1037bi</td>
<td>If the program was designed as a 20 hour program then it would be impossible to fit in looking at the links in that time frame. The links were interesting but did not have time to fully investigate</td>
</tr>
<tr>
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<td>E1039xh</td>
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<td>13</td>
<td>E1044oi</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>E1047bf</td>
<td>Probably too many links sucked up too much time</td>
</tr>
<tr>
<td>31</td>
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<td>17</td>
<td>E1051gu</td>
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<tr>
<td>23</td>
<td>E1070fp</td>
<td>For time poor people, it will help if a concise form is also available.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>The links may have distracted at times &amp; did make the course more time consuming, but they were very good &amp; I have documented them for future reference.</td>
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<tr>
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<td>37</td>
<td>i1061nw</td>
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<tr>
<td>38</td>
<td>i1067om</td>
<td>Sorry I didn't use many (no time)</td>
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## Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
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<th>Question 8b: The subject material was generally new to me.</th>
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<td>E1001an</td>
<td>I know a few basic things but this program was much more in depth and covered a greater scope of subjects that a pharmacist does when involved in palliative care that I haven't considered before</td>
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<td>E1010nw</td>
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<tr>
<td>4</td>
<td>E1011wa</td>
<td>Some areas were new to me, but putting everything together was extremely helpful in all areas.</td>
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<tr>
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<td>E1012yh</td>
<td>A lot of info was revision but I also learnt a lot, found some useful tools and have used more info in my pharmacy.</td>
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<tr>
<td>1</td>
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<td>I was fortunate to spend some time in Hospital Pharmacy 15 years ago when fixed interval morphine was very much the regime.</td>
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</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>A lot of info was new, but there were things that I already knew, but to have it all in one area in categories was very useful.</td>
</tr>
<tr>
<td>14</td>
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<td></td>
</tr>
<tr>
<td>28</td>
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<tr>
<td>19</td>
<td>E1031k1</td>
<td>In retail pharmacy with no affiliations with nursing homes/retirement villages/respite care units, the only real contact is with regular customers and tier carers. Sometimes just on the edge.</td>
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<td>22</td>
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<td>I often wondered how some subjects could be unfolded in my pharmacy in a short high pressure time frame</td>
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<tr>
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<td>E1044oi</td>
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<tr>
<td>18</td>
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<td>whilst these issues are dealt with quite frequently it was good to refocus on them</td>
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<td>17</td>
<td>E1051gu</td>
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</tr>
<tr>
<td>23</td>
<td>E1070fp</td>
<td>Some of the material and info may not be relevant to the practice of pharmacy at this moment.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>some material was new but some was familiar</td>
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<tr>
<td>35</td>
<td>i1054zz</td>
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<td>10</td>
<td>i1060ks</td>
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<td>37</td>
<td>i1061nw</td>
<td>I found the information very useful</td>
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### Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

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<th>Question 10b: The format of the subject material encouraged me to analyse my own clinical practice.</th>
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<td>The way in which the information was presented allowed me to consider how palliative care could be integrated into the pharmacy to become part of the support network of a palliative care team.</td>
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<td>34</td>
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<tr>
<td>36</td>
<td>E1007pr</td>
<td>I now supply quite a lot of written info, have a little library of books, resource folder with websites etc</td>
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<tr>
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<td>32</td>
<td>E1010nw</td>
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</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>I have tried to use the material in my dealings with clients. In some areas it has made me more hesitant where perhaps spontaneity is best. I need to work at my communication skills.</td>
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<td>E1023nn</td>
<td>Self reflection is very valuable in learning for yourself. Makes you really think about what you would do.</td>
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<td>It gave me some insight into the different stages of PC</td>
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<td>Was good to continual test yourself</td>
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<td>E1070fp</td>
<td>This course made me more careful in the way I speak to cancer patients of family members, and the way I offer advice.</td>
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## Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
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<th>Question 17b: The Discussion Group helped me to network with other pharmacists and specialists about palliative care issues.</th>
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<tbody>
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<td>E1001an</td>
<td>Although people were entering comments, there was no real networking or contacting each other, it went no further.</td>
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<td>E1003ym</td>
<td>Due to time commitments I didn't access the Discussion groups.</td>
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<td>E1007pc</td>
<td>I didn't go to the discussion group</td>
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<td>41</td>
<td>E1009er</td>
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</tr>
<tr>
<td>32</td>
<td>E1010mwy</td>
<td>I found the discussion group not that friendly. I found it hard to see what other people were saying. Maybe it could have been better displayed.</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>I worked through the modules in order, I did like to see other pharmacists answers on the notice board, it was interesting . I didn't use the discussion group, I didn’t feel comfortable enough with using this.</td>
</tr>
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<td>I did not use the chat group as much as I could have. Could expand the number of links to the discussion group.</td>
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<tr>
<td>8</td>
<td>E1019mq</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>Once I worked out how to use it - it was great.</td>
</tr>
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<tr>
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<td>E1028jh</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>E1031kl</td>
<td>Time permitting I could have done more with the Discussion group but with time restraints at the pharmacy and not being on-line at home, this was difficult.</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>22</td>
<td>E1034iy</td>
<td>Entry into the discussion group was limited by the time i had to complete the work</td>
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<td>E1035uy</td>
<td>didn't use</td>
</tr>
<tr>
<td>42</td>
<td>E1037bl</td>
<td>The discussion group was the only part I didn't use because of confusion with access and how I was going to use it. I also found many questions in the practice points questions ambiguous and I wasn't clear on the purpose of some of the questions.</td>
</tr>
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<td>E1044oi</td>
<td></td>
</tr>
<tr>
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<td>E1047bf</td>
<td>tended to ignore this as this project took lots of time as it was!!!</td>
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<tr>
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<td>E1050ju</td>
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<tr>
<td>17</td>
<td>E1051gu</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>E1070fp</td>
<td>I did not use the Discussion Group because this is new to me and I was not comfortable with it.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>this was a great idea. Will it stay online for future networking?</td>
</tr>
<tr>
<td>35</td>
<td>i1054zz</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>i1060ks</td>
<td>I wasn't comfortable to use the Discussion Group, although I did read other’s responses.</td>
</tr>
<tr>
<td>37</td>
<td>i1061uw</td>
<td>more activities / multiple choice / case studies would have been useful (especially with areas provided)</td>
</tr>
<tr>
<td>38</td>
<td>i1067om</td>
<td>Sorry didn't use it (our internet is too slow, so I mainly used the CD)</td>
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Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

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<th>Question 19d: I used the following other resources whilst working with the program.</th>
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<tbody>
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</tr>
<tr>
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<td>E1003ym</td>
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<tr>
<td>34</td>
<td>E1004ok</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td>educational cd on mental illness... had articles on grief, depression etc [ sorry it is not with me now don't know title]</td>
</tr>
<tr>
<td>29</td>
<td>E1008as</td>
<td>e-mims -micromedex</td>
</tr>
<tr>
<td>41</td>
<td>E1009er</td>
<td>Google</td>
</tr>
<tr>
<td>32</td>
<td>E1010mw</td>
<td>I didn't see that it was required to use the above, as the programme seemed to provide all the information required.</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>An educational cd on mental health[i don't have it here for the exact title]The cancer council booklets on various topic.</td>
</tr>
<tr>
<td>39</td>
<td>E1012yh</td>
<td>I used (and continue to use) a number of the on line sites used in the program. I also use Micromedex for drug and CAM information.</td>
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<td>8</td>
<td>E1019mq</td>
<td>e-mims - AusDI</td>
</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>Emims</td>
</tr>
<tr>
<td>14</td>
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<tr>
<td>28</td>
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<tr>
<td>22</td>
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<tr>
<td>15</td>
<td>E1035uy</td>
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<td>20</td>
<td>E1040gj</td>
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<tr>
<td>13</td>
<td>E1044oi</td>
<td>mims Hollands-To refer</td>
</tr>
<tr>
<td>18</td>
<td>E1047bf</td>
<td>Micromedic, e-mims APF</td>
</tr>
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<td>17</td>
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<td>23</td>
<td>E1070fp</td>
<td>AusDi</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>MIMS, APF</td>
</tr>
<tr>
<td>35</td>
<td>l1054zz</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>l1060ks</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>l1061nw</td>
<td>Mims, Merk manual</td>
</tr>
<tr>
<td>38</td>
<td>l1067om</td>
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</table>
### Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
<thead>
<tr>
<th>ID</th>
<th>user_id</th>
<th>Question 21h: As a result of doing the program, I consulted/collaborated with the other following people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>E1001an</td>
<td>Sadly, whilst doing the program we had no palliative care patients using the pharmacy, I am sure that I will be more proactive in communicating with patients and other health professionals in future.</td>
</tr>
<tr>
<td>43</td>
<td>E1002rb</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>E1003ym</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>E1004ok</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td>dietician</td>
</tr>
<tr>
<td>29</td>
<td>E1008as</td>
<td>As a result of the program I have used the notes in relation to narcotic switching to inform a Dr who has a patient on high doses of narcotics, and who wants to reduce the dose but is finding this difficult.</td>
</tr>
<tr>
<td>41</td>
<td>E1009er</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>E1010mw</td>
<td>nothing to add</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>I contacted the hospital dietician in regards to a patient</td>
</tr>
<tr>
<td>39</td>
<td>E1012yh</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>E1013vo</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>E1014th</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>E1017je</td>
<td></td>
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<tr>
<td>8</td>
<td>E1019mq</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>Haven't had many opportunities to collaborate with other health care professionals at this stage, it has just been with patients and their carer/families.</td>
</tr>
<tr>
<td>14</td>
<td>E1026de</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>E1028jh</td>
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<tr>
<td>19</td>
<td>E1031kl</td>
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<td>7</td>
<td>E1033yt</td>
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<td>22</td>
<td>E1034iy</td>
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<tr>
<td>15</td>
<td>E1035uy</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>E1037bl</td>
<td>I'm not sure if my communication with other palliative care professionals is going to change that much as it is my feeling that p'cists are not highly regarded by those professionals or that they undervalue our potential. That is where some education may be needed Eg GP's, nurses 'm sure they do not understand fully what pharmacists offer their patients. How many times do i get told that &quot;[Name], you're better than my Dr. U tell me much more and explain it very simply*** arrrrgh!!!</td>
</tr>
<tr>
<td>11</td>
<td>E1039xh</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>E1040gj</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>E1044o1</td>
<td>Have not had opportunity in our pharmacy as working part-time so not seeing patients or carers often enough, though on several occasions felt more comfortable talking to some patients</td>
</tr>
<tr>
<td>18</td>
<td>E1047bf</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>E1050ju</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>E1051gu</td>
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<tr>
<td>23</td>
<td>E1070fp</td>
<td></td>
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<tr>
<td>16</td>
<td>E1071bo</td>
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<td>35</td>
<td>i1054zz</td>
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<tr>
<td>38</td>
<td>i1067om</td>
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</table>
## Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
<thead>
<tr>
<th>ID</th>
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<th>Question 23: The program could be improved by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>E1001an</td>
<td>Perhaps a better layout: navigation. I found the case studies useful and would find some more of that useful. Comments of a practical nature from specialists perhaps an online chat/question and answer with palliative care specialists.</td>
</tr>
<tr>
<td>12</td>
<td>E1003ym</td>
<td>I felt there was too much material on the non therapy issues. It was interesting and good background knowledge but not particularly relevant to everyday community pharmacy practice at this stage. The participation of pharmacists as primary health care providers in the general health care team is still in its infancy.</td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>E1008as</td>
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</tr>
<tr>
<td>41</td>
<td>E1009er</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>E1010mw</td>
<td>The programme seems to have been aimed towards hospital pharmacists, not the community pharmacists it was supposed to be aimed at. Maybe we need a questionnaire to see what we actually do in our pharmacies re palliative care &amp; work the programme up from that.</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>If it were possible to have better guidelines to finding resources in your own area. I found this difficult &amp; came across many dead ends. Often, phonecalls would be never ending sent from one area to another. I think there is a lot of well written literature for carers &amp; patients but not a lot of physical resources.</td>
</tr>
<tr>
<td>39</td>
<td>E1012yh</td>
<td>More activities. More use of discussion group. Follow up/refresher after 3 months, 6 months, 12 months. Me timetabling more hours to complete on time!</td>
</tr>
<tr>
<td>30</td>
<td>E1013vo</td>
<td>less complicated information wise</td>
</tr>
<tr>
<td>1</td>
<td>E1014th</td>
<td>(I thought it was great.)</td>
</tr>
<tr>
<td>40</td>
<td>E1017je</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>E1019mq</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>Pharmacists need to realise that they need to really sit down and work through this quietly. It is very hard to do it properly whilst serving customers.</td>
</tr>
<tr>
<td>14</td>
<td>E1026de</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>E1028jh</td>
<td>No direct suggestion but hope the feedback will help you</td>
</tr>
<tr>
<td>19</td>
<td>E1031kh</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>E1033yt</td>
<td>Breaking modules down to 15 minute blocks. You can do this yourself but much easier if done for you within the modules. PSA does this with their online learning and works really well.</td>
</tr>
<tr>
<td>22</td>
<td>E1034ly</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>E1035uy</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>E1037bl</td>
<td>a realistic time frame to complete this study. 20 hours is way too short. More like 35-40 hours needed to really do it properly. I feel like I have cheated a bit by not following through to links and discussion groups but I want this to be realistic so I have tried as much to adhere to your timeframe</td>
</tr>
<tr>
<td>11</td>
<td>E1039xh</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>E1040gj</td>
<td>Would have liked more people joining discussion group. maybe one session where we could have forum at college</td>
</tr>
<tr>
<td>13</td>
<td>E1044oi</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>E1047bf</td>
<td>less volume and fewer links</td>
</tr>
<tr>
<td>31</td>
<td>E1050ju</td>
<td>send out a handbook with basic notes to scribble on while doing program. would cut down on the amount of time on computer. I personally learn better when i have things written down paper</td>
</tr>
<tr>
<td>17</td>
<td>E1051gu</td>
<td>I thought the case studies are a good learning tool so maybe incorporating more of it into the program would be useful</td>
</tr>
<tr>
<td>23</td>
<td>E1070fp</td>
<td>Make a hard copy available, it makes referring to other sections easy to do.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>It was quite long &amp; detailed as I spent a lot of time on links. This would be fine if there wasn't a time limit.</td>
</tr>
<tr>
<td>35</td>
<td>i1054zz</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>i1060ks</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>i1061nw</td>
<td>more questions and answers. Better summaries at end of each module. More case studies</td>
</tr>
<tr>
<td>38</td>
<td>i1067om</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
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<tr>
<th>ID</th>
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<th>Question 25: Any other comments welcome</th>
</tr>
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<tbody>
<tr>
<td>3</td>
<td>E1001an</td>
<td>The information presented was informative and interesting and useful. The formate/navigation of the site was cumbersome and perhaps a bit boring considering what you can now do with animation etc to make learning more interesting. Although pressed for time I was determined to complete the program as I found it very interesting. It has not greatly impacted on my pharmacy as yet but as I consult to other pharmacies doing med. Reviews I believe I will benefit form completing the program. I could have found it useful a few yrs ago managing customers that were dying of HIV. Thank you for the opportunity to participate.</td>
</tr>
<tr>
<td>12</td>
<td>E1003ym</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>E1004ok</td>
<td>The program is perhaps ahead of its time. This type of role for community pharmacists is very limited at the moment. The profession is starting to move in that direction with the advent of Home Medicines Reviews but widespread participation in a collaborative manner with other health professionals is not yet common place.</td>
</tr>
<tr>
<td>36</td>
<td>E1007pc</td>
<td>Enjoyed it thankyou for allowing me to do it</td>
</tr>
<tr>
<td>29</td>
<td>E1008as</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>E1009er</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>E1010mw</td>
<td>If the pharmacist had very little knowledge of palliative care I would recommend the programme, despite what I have already said.</td>
</tr>
<tr>
<td>4</td>
<td>E1011wa</td>
<td>I really enjoyed the course, it was never a chore, except finding the time. I have started 2 resource folders one for me &amp; one for clients , I have a small library of information which already well used. I think the course has given me the confidence to proceed further, I have a lot more new resources open to me &amp; I think it will help me provide a better service to these clients. Thank you very much.</td>
</tr>
<tr>
<td>39</td>
<td>E1012yh</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>E1013vo</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>E1014th</td>
<td>It would have been better to have had the Evidence of completion sheet from the beginning. Thank you for the charts/tables etc that will be very useful in our practice.</td>
</tr>
<tr>
<td>40</td>
<td>E1017je</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>E1019mq</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>E1023mn</td>
<td>I thought that this was a fantastic learning program. It covered a wide range of topics, and let you really think about your practice, not just answer questions. Very worthwhile, and hopefully can use a lot more of what I have learnt in the future. Valuable learning tool for students and pharmacists.</td>
</tr>
<tr>
<td>14</td>
<td>E1026de</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>E1028jh</td>
<td>Took a while to get used to learning on a computer – both CD-rom &amp; internet, but once I got used to it I enjoyed it. Thought it was definitely worthwhile even tho it was hard to find the time between work &amp; kids &amp; no energy at the end of the day! Think it would be a good thing for more pharmacists to do if possible. Will we still be able to access the site prn? Cheers!</td>
</tr>
<tr>
<td>19</td>
<td>E1031kl</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>E1033yt</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>E1034iy</td>
<td>Sometimes a felt the cases were depressing and quite sad which in real life is a lot to carry while running a pharmacy</td>
</tr>
<tr>
<td>15</td>
<td>E1035uy</td>
<td>15 minutes isn’t long enough to answer this. I wrote comments and was thinking about it, then it was lost. Sigh.</td>
</tr>
</tbody>
</table>
### Appendix AJ continued - Post-program Evaluation questionnaire: Additional comments

<table>
<thead>
<tr>
<th>ID</th>
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<th>Comments</th>
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<tr>
<td>42</td>
<td>E1037bl</td>
<td>Question 25: Any other comments welcome, continued…</td>
</tr>
<tr>
<td>11</td>
<td>E1039xh</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>E1040gj</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>E1044oi</td>
<td>I am grateful that such programs are available so that I feel better equipped to provide better quality care in a pharmacy setting.</td>
</tr>
<tr>
<td>18</td>
<td>E1047bf</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>E1050ju</td>
<td>enjoyed doing program. was very informative and useful.</td>
</tr>
<tr>
<td>17</td>
<td>E1051gu</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>E1070fp</td>
<td>other topics like hypertension, diabetes can be presented in this format (with improvements, of course) This 15 minutes limit is ridiculous,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>when pharmacists have to fill this in at work, between customers.</td>
</tr>
<tr>
<td>16</td>
<td>E1071bo</td>
<td>Congratulations on a fine educational resource. I do hope the website will continue to be available for future reference.</td>
</tr>
<tr>
<td>35</td>
<td>i1054zz</td>
<td>This is an excellent program that I would recommend to any pharmacist especially the trainees who would benefit a lot from doing it. This will</td>
</tr>
<tr>
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<td></td>
<td>also include the young pharmacists as well. Another good thing about the program is that it actually comes on a disk so that when you are not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>able to accommodate the internet, you could still do some parts of the program. Good work.</td>
</tr>
<tr>
<td>10</td>
<td>i1060ks</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>i1061nw</td>
<td>Program was fantastic and definitely increased my ability to broach the subject with carers/patients with confidence. Patients seemed to be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>really keen to have someone to talk to. I would strongly recommend program be available to all pharmacists as a CPE program.</td>
</tr>
<tr>
<td>38</td>
<td>i1067om</td>
<td>Maybe next time (if you do it) you could get the pharmacist to write down how long it took as they go - I had no idea which dates I started</td>
</tr>
<tr>
<td></td>
<td></td>
<td>modules or how long it took to do each one.</td>
</tr>
</tbody>
</table>
## Appendix AK: 3-month Post-knowledge questionnaire, Question 16: Reflections about the program and how it may have impacted on the participants’ pharmacy practice

<table>
<thead>
<tr>
<th>ID</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>e1001an</td>
<td>Hard to say, flew back from overseas Wednesday, straight to work, second busiest night of the year exhausted, couldn't find the web site etc. etc. etc. but yes it has been useful - no more questions PLEASE!</td>
</tr>
<tr>
<td>e1002rb</td>
<td>The program has definitely improved my confidence in dealing with patients in palliative care. Although the pharmacy I work in most of the time has limited contact with palliative care I have recently taken up locuming work and have come across difficult prescriptions wording palliative care treatments that I would have found confusing and confronting previous to studying this program.</td>
</tr>
<tr>
<td>e1003ym</td>
<td>Certainly improved my confidence, particularly at finding information resources and familiarity with some I've had e.g. Therapeutic Guidelines. I found the program a little frustrating and feel perhaps an indexing/searching facility within the program may have helped e.g. finding information again was difficult if I couldn't exactly remember what section was included.</td>
</tr>
<tr>
<td>e1004ok</td>
<td>The application I practice of this knowledge is somewhat limited presently. Community pharmacists are not in reality part of the health care team in palliative care at this stage. HMR and RMMR have started to set pharmacists recognised for their clinical knowledge but as yet there is not widespread acceptance of this. Palliative care is also a specialised area in which community pharmacists have generally had a limited role. It will take time for further recognition of pharmacists' skills.</td>
</tr>
<tr>
<td>e1007pc</td>
<td>I still use the program; it has increase my interactions with my clients, increased my confidence to speak, advise and provide information to clients. I am more likely to refer clients to other health professionals. They are more likely yo ask my help and opinions, but it has not - I don't think - increased my position on the &quot;health care team&quot;. I have little communication with other health professionals. My clients and their carers are interacting more with me! but we haven't gone that next step.</td>
</tr>
<tr>
<td>e1008as</td>
<td>Participant did not complete the questionnaire</td>
</tr>
<tr>
<td>e1009er</td>
<td>Participant did not complete the questionnaire</td>
</tr>
<tr>
<td>e1010mw</td>
<td>The program was interesting, but has had little effect on my practice. I have a number of cancer patients on morphine who I have a good relationship with, but I find that most of the information in the course was not applicable in my practice.</td>
</tr>
<tr>
<td>e1011wa</td>
<td>Have just moved pharmacy to new Medical Centre (was closed for 2 weeks). So not talking to everyone for as long as I like whilst settling into new position. Have always used aspects of program but now having to think a lot more about medication (i.e. dosage changes/adjuvant therapy) etc. and keeping a close eye on carers - they often don't cope as well as we think they do.</td>
</tr>
</tbody>
</table>
Appendix AK continued - 3-month Post-knowledge questionnaire, Question 16: Reflections about the program and how it may have impacted on the participants’ pharmacy practice

<table>
<thead>
<tr>
<th>ID</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>e1012yh</td>
<td>Regular (6 monthly) updates - maybe 2-4 hour duration would be useful; refer to materials regularly to assist in my practice; also improved my confidence ni talking to other health care professionals in the palliative care area. An excellent program.</td>
</tr>
<tr>
<td>e1013vo</td>
<td>Far too deep and involved i.e. important and useful information but too deep.</td>
</tr>
<tr>
<td>e1014th</td>
<td>We work closely with the Community Health Palliative care staff and DVA staff. We are investigating an emergency medication kit for the staff to carry, especially if they are out of town and the doctor phone orders medication which could be used &quot;then&quot; rather than later once the doctor has returned to the pharmacy and gone back to the patient - can take up to 2 hours sometimes. Give the patient/carer some valuable time. They are special people.</td>
</tr>
<tr>
<td>e1017je</td>
<td>Overall, it's mainly about providing confidence. Having a good knowledge base of what a pharmacist would be expected to know in palliative care along with strategies for dealing with situations faced by these patients and carers, I have been proactive with them.</td>
</tr>
<tr>
<td>e1019mq</td>
<td>The program has been very useful in my pharmacy. I have learnt about taking time for these patients, and providing care &quot;as good as I can make it.&quot; Time allocation was difficult, but worthwhile. Thanks.</td>
</tr>
<tr>
<td>e1023mn</td>
<td>Since the program finished, I haven't come across too many palliative care patients, compared to whilst the program was running. It has definitely improved my confidence in order to interact with the patients and team members. It was a very helpful program. It covered all aspects and was easy to understand. Thumbs up!</td>
</tr>
<tr>
<td>e1026de</td>
<td>This course has helped with my listening and personal approach to the clients. This is also great source material for use of analgesics, opiates and medication.</td>
</tr>
<tr>
<td>e1028jh</td>
<td>Have referred back to it once or twice (not as often as I should or as I intended to); definitely made me more confident dealing with patients and their carers/families - feel I can make a positive difference to them, especially if pain not adequately managed, also more confident to deal with misconceptions; was quite time consuming (not too bad once I got the momentum going) - felt the &quot;CAM&quot; stuff was a bit too in depth; thought that most community pharmacists (and therefore patients) would benefit from doing the course, even if only the &quot;straight&quot; pharmacy sections; links to other reference sources were good and interesting; wouldn't recommend doing it on dial-up internet connection; gained confidence in dealing with &quot;emotional&quot; side of things, though this is still difficult; definitely worth doing!</td>
</tr>
</tbody>
</table>
Appendix AK continued - 3-month Post-knowledge questionnaire, Question 16: Reflections about the program and how it may have impacted on the participants’ pharmacy practice

<table>
<thead>
<tr>
<th>ID</th>
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<tr>
<td>e1031kl</td>
<td>Being a community pharmacist and not servicing any nursing homes or private hospitals, it is not all that easy to become very involved with palliative care patients. Most of the care and involvement with the patient is in pre-palliative care and then often from a distance, usually through the carer. It is only with being pro-active that I, as the pharmacist, become part of the ‘big picture.’ Just dispensing prescriptions for palliative care patients has minimal impact, but being able to communicate with, show interest, care and having a better understanding of ‘cancer palliative care’, gives me more meaning. This area of medicine is probably the most emotional of all. Feeling that one can offer more than just a supply service, means a great deal to me. I, like many other pharmacists, deal with the very sick and dying. In my pharmacy, with an aged clientele (being here for 30 years), I have always been very community minded (now the only pharmacy in the suburb). I do have a lot of attachment to the people and knowing more about palliative care has given me a better understanding and confidence. It also helps me deal with friends and relatives who maybe in this category, far better than before.</td>
</tr>
<tr>
<td>e1033yt</td>
<td>We need to know more about how to cope with emotional stress for ourselves.</td>
</tr>
<tr>
<td>e1034ij</td>
<td>I found the program a lot more intensive than I originally anticipated. The case studies in most cases I thought were very sad. Patients that are in palliative care, now, get a more understanding pharmacist. I can ask more understanding questions which relaxes the patient.</td>
</tr>
<tr>
<td>e1035uy</td>
<td>Participant did not complete the questionnaire.</td>
</tr>
<tr>
<td>e1037bl</td>
<td>It's very hard to maintain your knowledge if contact with palliative care patients is not great. I still find reality of pharmacy practice timewise provides inadequate time for proper palliative care.</td>
</tr>
<tr>
<td>e1039xh</td>
<td>The impact of the program for me personally is being able to help patients with their medication in palliative care. I currently have 2 patients who use opioids for pain relief and I can confidently give them advice. I can talk to their families and their doctor and feel I am helping in some small way. I found the program excellent but a little long and most information very relevant.</td>
</tr>
<tr>
<td>e1040gj</td>
<td>Participant did not complete this question</td>
</tr>
<tr>
<td>e1044oi</td>
<td>The program was excellent (though time consuming) in equipping me with the knowledge needed (or where it would be found) for the pharmacy practice to function as an effective member of the palliative care team. Full impact on pharmacy practice is yet to be seen, though there has been occasions where the relief in a carer's face because you can empathise with their situation and know where/who to refer is evident.</td>
</tr>
<tr>
<td>e1047bf</td>
<td>Participant did not complete the questionnaire</td>
</tr>
</tbody>
</table>
### Appendix AK continued - 3-month Post-knowledge questionnaire, Question 16: Reflections about the program and how it may have impacted on the participants’ pharmacy practice

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<tbody>
<tr>
<td>e1050ju</td>
<td>Use program as reference source when I need certain drug information or get queries I know where to look within modules.</td>
</tr>
<tr>
<td>e1051gu</td>
<td>This program has given me the confidence to better help and understand palliative care patients.</td>
</tr>
<tr>
<td>e1070fp</td>
<td>I felt more confident in interacting with patients in palliative care. I understand better their feelings, their families’ feelings and their concerns. Not all areas of the course is relevant e.g. parenteral administration of drugs. I am also more comfortable with dispensing of high dosages of opioids.</td>
</tr>
<tr>
<td>e1071bo</td>
<td>The program has been very useful and has already given me the opportunity to help some cancer patients. I do refer back to my notes from time to time and have also used some of the web sites. The only negative aspect of the program was the length of the time required to get through it all, but I do realise it was necessary in order to give so much detail. Thank you for a great learning tool.</td>
</tr>
<tr>
<td>i1054zz</td>
<td>I have not been able to use the program due to not having time but once I have the time I would want to go back to the course and read more in depth and go through the information again. It is a very well explained, interesting CD. It is something that I can always rely on to find information on palliative care that I cannot find in text books. Interacting with patients who have family issues or themselves have cancer, I have more empathy and more understanding towards them, I need to spend more time with them to help them in anyway I could. Well done to the people who have created or helped make this program available.</td>
</tr>
<tr>
<td>i1060ks</td>
<td>I really enjoyed doing the program but I had to be very disciplined in allocating time. I feel it has helped me immensely in dealing with patients in general but particularly palliative care patients and has enabled me to have the resources to better able to respond to their needs. Well done!</td>
</tr>
<tr>
<td>i1061nw</td>
<td>Participant did not complete questionnaire</td>
</tr>
<tr>
<td>i1067om</td>
<td>The program was very informative, however I haven’t had a chance to use any of it in daily dispensing yet. I aim to go through the program again at a later date to refresh my memory.</td>
</tr>
</tbody>
</table>
## Appendix AL: Descriptive analysis of pre-program interventions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Type of DRP</th>
<th>Description of DRP</th>
<th>Recommendation to resolve DRP</th>
<th>Accepted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Test</td>
<td>Difficulty using dosage form &amp; Other compliance problem&lt;br&gt;lack of knowledge/confusion about therapy</td>
<td>Patient finds tablets hard to swallow &amp; requested injectables from specialist. He refused. Patient’s family have been crushing tablets (MS Contin to be swallowed whole). Patient unclear as to why doctor would not give injectables if having difficulty swallowing.</td>
<td>Verbal counselling: Suggested doctor preferred long-acting pain relief with tablets (MS Contin); perhaps swallow with pureed food/soft food, or maybe ask doctor for syrup form.&lt;br&gt;Verbal counselling &amp; Refer to GP: Suggested talking to doctor in 2 days re syrup form perhaps</td>
<td>Yes.</td>
</tr>
<tr>
<td>2</td>
<td>Test</td>
<td>Condition not treated adequately</td>
<td>Pain sometimes not adequately controlled with MS Contin bd.</td>
<td>Contacted doctor &amp; treatment recommended: Panamax 2 tablets 4h for breakthrough pain</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Control</td>
<td>Lack of knowledge/confusion about therapy</td>
<td>Carer unaware of need to rotate site for Transiderm Nitro patch (supplied via hospital).</td>
<td>Verbal counselling: Counsel on rotating site, select non-hairy area on upper body/arms. Apply pressure for 30 secs to patch to form good contact with skin.</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Test</td>
<td>Other Dose/Duration problem</td>
<td>Doctor ordered Oxycontin 30mg which is non-existent.</td>
<td>Contacted GP: Suggested changing to 1 40mg bd.</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Test</td>
<td>Condition not treated adequately</td>
<td>Bad constipation, even when on Lactulose 20ml d. Hasn’t opened the bowel for 3 days.</td>
<td>Treatment recommended: Durolax 10mg PR pn, keep taking Lactulose. Increase water consumption &amp; fibre sources.</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Test</td>
<td>Lack of knowledge/confusion about therapy</td>
<td>Patient still having a few MS Contin 30mg. Should he take together with Oxycontin 10mg and 40mg?</td>
<td>Verbal counselling: Patient should finish all of the MS Contin 30mg, then start taking Oxycontin 40mg bd &amp; Oxycontin 10mg bd pn.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Appendix AL continued: Descriptive analysis of *pre-program* interventions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
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<th>Description of DRP</th>
<th>Recommendation to resolve DRP</th>
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</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Test</td>
<td>Condition not treated</td>
<td>Carer rang saying patient was very agitated &amp; restless. Wanted to know if Valium is available here (she is from the Phillipines).</td>
<td>Refer to GP: Yes, Valium available but I advised to ring GP &amp; explain what was happening to the patient. GP contacted me &amp; requested Murelax 7.5mg bd to be initiated.</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Control</td>
<td>Other Drug selection problem</td>
<td>Patient’s wife requested that patient needs Ordine 10mg/mL mixture, needed prescription &amp; clarify strength (continuing supply).</td>
<td>Other recommendation: Rang doctor &amp; requested strength to be ordered &amp; post a script.</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Control</td>
<td>Other Drug selection problem</td>
<td>Patient’s wife requested Rivotril oral liquid (continuing supply).</td>
<td>Other recommendation: Rang doctor to order Rivotril, requested for a prescription.</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Control</td>
<td>Other Drug selection problem</td>
<td>Patient’s wife requested wrong strength of Durogesic patch (continuing supply)</td>
<td>Other recommendation: Rang doctor to clarify what strength was to be used &amp; suggested by palliative nurse (strength was 50 and patient’s wife requested the wrong one i.e. 25 or 75).</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>Test</td>
<td>Other Education/Information problem</td>
<td>Scripts filled: MS Contin 10mg, MS Contin 30mg</td>
<td>Verbal counselling: Counselling about taking pain tablets. Other recommendation: Treatment recommended (advised to take Coloxyl &amp; Senna 2 bd to prevent constipation).</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Appendix AM: Descriptive analysis of *during-program* interventions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Type of DRP</th>
<th>Description of DRP</th>
<th>Recommendation to resolve DRP</th>
<th>Accepted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Test</td>
<td>Non-clinical</td>
<td>Patient is receiving medicines from Western Private Hospital Pharmacy- rang pharmacist for Prescription Record Form (PRF) print-out- getting close to Safety Net.</td>
<td>Other recommendation: Contacted pharmacists at Western Private Hospital Pharmacy. PRF faxed.</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Control</td>
<td>Incorrect frequency</td>
<td>Patient was on Tramadol 50mg qid prn in the past. Now prescribed 100mg SR qid prn.</td>
<td>Dose frequency/schedule change: Doctor not available. No notes in file at surgery. Recommended dose reduction to 100mg bd prn. Pending a check with the doctor.</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>Test</td>
<td>Other Education/Information problem</td>
<td>Scripts filled: Diamicron MR 30mg, Diabex 1000mg.</td>
<td>Verbal counselling: Counselling about taking diabetic tablets.</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Test</td>
<td>Lack of knowledge/confusion about condition</td>
<td>Scripts filled: MS Contin 10mg, MS Contin 30mg, Pramin 10mg. Patient feels nauseous and constipated sometimes, takes Pramin only when needed for nausea- confused.</td>
<td>Verbal counselling: Advised to take Pramin 1 qid regularly rather than only when needed for nausea, and regular Coloxyl and Senna 2 bd for constipation.</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>Test</td>
<td>Non-clinical</td>
<td>Scripts filled: Isoptin 180mg d, Diamicron MR 30mg 1 d, Diabex 1000mg mdu. Patient rang up- can’t collect medicines due to illness – what to do?</td>
<td>Verbal counselling. Other recommendation: Deliver medicines to patient’s home.</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Test</td>
<td>Non-clinical</td>
<td>Scripts filled: Pramin. Patient rang up- can’t collect medicine due to illness – what to do?</td>
<td>Verbal counselling. Other recommendation: Deliver medicines to patient’s home.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Appendix AN: Expert Review Panel's assessment of pharmacists' interventions

<table>
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<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Actual or Potential Consequence or Impact</th>
<th>Likelihood of Re-Occurrence</th>
<th>Classification of Risk</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Test</td>
<td>Minor – Major</td>
<td>Possible – Likely</td>
<td>Moderate – Extreme</td>
<td>One member felt that the risk of hospitalisation to recalibrate the patient's pain management was high, and thus rated the consequence/impact as major. The remaining members felt that this risk was not so high because of the patient was taking a low dose of MS Contin; they therefore rated the consequence/impact as Minor/Moderate. The lack of a breakthrough dose of pain medicine, and communication problems with the specialist, were a general concern. Three members suggested that the pharmacist should have contacted the GP to recommend an alternative to MS Contin in combination with a breakthrough medicine.</td>
</tr>
<tr>
<td>2</td>
<td>Test</td>
<td>Minor - Moderate</td>
<td>Possible - Likely</td>
<td>Moderate - High</td>
<td>One member stated that they rated the consequence/impact as minor because it appeared as if the pharmacist's intervention of adding Paracetamol worked, indicating that the patient's problem may have only been minor. Four members said that there was no breakthrough dose of an opioid; liquid Morphine or Oxycodeone with or without Paracetamol was suggested. One member stated that the conversion of Oxycontin to MS Contin was too low. The disparity between the date of the intervention and the medication history was noted and investigated (the patient was on MS Contin at that time, however, the history indicated that Oxycontin was being taken). Refer to intervention number 2: Appendix AO.</td>
</tr>
</tbody>
</table>

221
### Appendix AN continued: Expert Review Panel’s assessment of pharmacists’ interventions

<table>
<thead>
<tr>
<th>Intervention No.</th>
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<tbody>
<tr>
<td>3</td>
<td>Control</td>
<td>Insignificant - Minor</td>
<td>Unlikely - Possible</td>
<td>Low - Moderate</td>
<td>The Panel stated that the consequence/impact was insignificant/minor because if the pharmacist hadn’t suggested to rotate the Transderm Nitro patch, the patient may have got a red rash at most, which probably wouldn’t have warranted a visit to the GP or hospitalisation. One member was concerned about the patient’s use of the Durogesic patch because of the inappropriate use of the Transderm Nitro patch. They also stated that the daily administration of the Durogesic patch was unusual, even in the palliative care setting, and that this should have been investigated by the pharmacist. Another member commented on the lack of a breakthrough dose of pain medicine (oral/parenteral).</td>
</tr>
<tr>
<td>4</td>
<td>Test</td>
<td>Insignificant - Minor</td>
<td>Unlikely - Likely</td>
<td>Low - Moderate</td>
<td>The Panel rated the consequence/impact as insignificant/minor because they believed that the drug-therapy problem (correction of strength of Oxycontin prescribed) detected by the pharmacist was resolved without any impact on the patient. One member was concerned about the lack of a breakthrough dose of a pain medicine, and the lack of an aperient to treat/prevent constipation.</td>
</tr>
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<tr>
<td>5</td>
<td>Test</td>
<td>Minor – Moderate</td>
<td>Possible - Likely</td>
<td>Moderate - High</td>
<td>One member felt that the risk of hospitalisation to recalibrate pain management, because of constipation, was high, and thus rated the consequence/impact as moderate. Two members stated that the pharmacist should have suggested Coloxyl and Senna or Movicol instead of Durolax suppositories, and that Lactulose is no longer recommended because it causes gas. Another two members stated that recommending an increase in fibre consumption is not always appropriate for palliative care patients. The Panel wished to know whether the pharmacist rang the GP to inform them of their recommendation, or to discuss the matter further, and who had suggested Durolax suppositories as an alternative. This was noted and investigated. Refer to intervention number 2: Appendix AO.</td>
</tr>
<tr>
<td>6</td>
<td>Test</td>
<td>Insignificant - Major</td>
<td>Unlikely - Likely</td>
<td>Low - Extreme</td>
<td>The Panel stated that there was insufficient information to assess the intervention, and that the pharmacist’s recommendation to take Oxycontin 10mg (controlled release) as a prn dose was inappropriate. One member was concerned about the lack of an aperient to treat/prevent constipation. The disparity between the date of the intervention and the medication history was noted and investigated (the patient asked the pharmacist if they should complete taking MS Contin and then start taking Oxycontin, but the history indicated that MS Contin was not being taken at that time). Refer to intervention number 2: Appendix AO.</td>
</tr>
</tbody>
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Appendix AN continued: Expert Review Panel’s assessment of pharmacists’ interventions

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<tbody>
<tr>
<td>7</td>
<td>Test</td>
<td>Insignificant – Moderate</td>
<td>Unlikely - Possible</td>
<td>Low - High</td>
<td>Some Panel members rated the consequence/impact as moderate because they felt that if the pharmacist hadn’t intervened (referred patient to GP), the patient may have remained symptomatic (agitated), causing distress. However, other members felt that the pharmacist didn’t intervene, but rather provided drug information which is a part of routine care. One member stated that Murelax was not the drug of choice, however, didn’t indicate which medicine they would have recommended instead. Another member was concerned about the lack of an aperient for the patient to use in conjunction with their pain medicines, and the dose frequency of the Dexamethasone supplied (daily, bd or qid?)</td>
</tr>
<tr>
<td>8</td>
<td>Control</td>
<td>Insignificant – Moderate</td>
<td>Possible</td>
<td>Low - High</td>
<td>Some Panel members believed that the consequence/impact was insignificant/minor because the drug-therapy problem (clarification of strength of Ordine mixture and subsequent contact with GP to organise a prescription) detected and resolved by the pharmacist was a part of routine care. However, others felt that the consequence/impact was moderate because the pharmacist’s intervention was cost-saving as the patient didn’t have to visit the GP for a script. The Panel wanted to know if the patient had taken Ordine mixture before (not indicated by medication history, so were there scripts supplied before/ was it recommended now?). This was noted and investigated. Refer to intervention number 2: Appendix AO.</td>
</tr>
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Appendix AN continued: Expert Review Panel’s assessment of pharmacists’ interventions

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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Control</td>
<td>Minor – Moderate</td>
<td>Unlikely - Likely</td>
<td>Moderate - High</td>
<td>As for intervention 8 (same patient &amp; pharmacist). The Panel wanted to know if the patient had taken Rivotril before (not indicated by medication history, so were there scripts supplied before/was it recommended now?). This was noted and investigated. Refer to intervention number 2: Appendix AO. Some Panel members commented that the pharmacist should have suggested to the GP that a medication review be undertaken for the patient, considering that the carer was requesting medicines for symptom control (all of which hadn’t been prescribed previously according to the medication history) – possibly indicating that there were unaddressed underlying problems.</td>
</tr>
<tr>
<td>10</td>
<td>Control</td>
<td>Minor – Major</td>
<td>Unlikely - Likely</td>
<td>Moderate - Extreme</td>
<td>As for intervention 8 (same patient &amp; pharmacist). The Panel stated that there was insufficient information to assess the intervention – they were unclear about whether the patient was taking one (50 mcg/hr) or both strengths (50 &amp; 100 mcg/hr) of the Durogesic patch, and whether there was a script supplied. This was noted and investigated. Refer to intervention number 2: Appendix AO. One member commented that it’s the palliative care nurse/GP’s responsibility, and not the carer’s, to contact the pharmacist for medicines. In response, another member stated that requests for prescriptions most commonly come from patients/carers/ and rarely from nurses/GPs.</td>
</tr>
</tbody>
</table>
### Appendix AN continued: Expert Review Panel’s assessment of pharmacists’ interventions

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<th>Comments</th>
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<tbody>
<tr>
<td>11</td>
<td>Test</td>
<td>Insignificant – Moderate</td>
<td>Possible – Almost certain</td>
<td>Moderate - Extreme</td>
<td>The Panel commented that the pharmacist’s recommendation of Coloxyl and Senna to treat the patient’s constipation was good, however, only on face value, because only 10 days ago, the same pharmacist recommended Durolax suppositories (intervention 5). They felt that the pharmacist made a decision on the basis of medication rather than a discussion with the patient, and that the GP should have been contacted and/or a medication review should have been suggested. The Panel also stated that if the pharmacist hadn’t suggested Coloxyl and Senna, there would have been a moderate decrease in symptoms; thus, most members rated the consequence/impact as moderate. One member wished to know whether the patient continued to be constipated with no bowel motions, and for what duration. This was noted and investigated. Refer to intervention number 2: Appendix AO.</td>
</tr>
<tr>
<td>12</td>
<td>Test</td>
<td>Insignificant – Minor</td>
<td>Rare - Likely</td>
<td>Low - High</td>
<td>The consequence/impact was rated as insignificant/minor because the Panel felt that cost doesn’t have a major impact on patients’ care and symptom control. However, at the same time they acknowledged that access to medicines revolves around cost – and because many palliative care patients/carers are concerned about costs, this may impact on symptom control. One member was concerned about the lack of a breakthrough dose of pain medicine, and the lack of an aperient to treat/prevent constipation.</td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td>13</td>
<td>Control</td>
<td>Moderate – Major</td>
<td>Possible - Likely</td>
<td>High – Extreme</td>
<td>The Panel stated that the pharmacist’s intervention was good (recommendation of dose reduction of Tramadol 100mg qid prn to 100mg bd prn), considering the patient was 86 yrs old and was on a SSRI (Zoloft) – this combination could have lead to serious adverse effects. The consequence/impact was thus rated as moderate/major. However, the Panel also commented that the pharmacist’s suggestion of a prn dose was inappropriate: 100mg bd (for continuous pain relief) or 50mg qid prn (for breakthrough pain) should have been suggested instead.</td>
</tr>
<tr>
<td>14</td>
<td>Test</td>
<td>Insignificant – Moderate</td>
<td>Unlikely - Likely</td>
<td>Low - High</td>
<td>The Panel stated that there was insufficient information to assess the intervention – they wanted to know what prompted the pharmacist to counsel the patient, and what was advised. This was noted and investigated. Refer to intervention number 2: Appendix AO. They also felt that the pharmacist’s labelling of Diabex and Diamicron with mdu (take as directed) instructions was incorrect, negating the verbal counselling given. One member rated the impact/consequence as moderate because they felt that if the patient was confused about their medicines, the risk of medication misadventure (hypoglycaemia) would be high, especially given that there were no specific instructions on the labels. One member was concerned about the lack of a breakthrough dose of pain medicine, and the lack of an aperient to treat/prevent constipation.</td>
</tr>
</tbody>
</table>
Appendix AN continued: Expert Review Panel’s assessment of pharmacists’ interventions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Actual or Potential Consequence or Impact</th>
<th>Likelihood of Re-Occurrence</th>
<th>Classification of Risk</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Test</td>
<td>Insignificant – Major</td>
<td>Possible - Likely</td>
<td>Low - Extreme</td>
<td>One Panel member stated that there was some distance between the commencement of opioids and constipation for the patient to be truly constipated; it was suggested that the patient could’ve been hypercalcaemic. Another member felt that the patient’s symptoms may have been due to non-adherence; the low frequency of supply of Pramin supported this. It was also suggested that the pharmacist should’ve referred the patient to the GP and suggested an alternative to Coloxyl and Senna.</td>
</tr>
<tr>
<td>16</td>
<td>Test</td>
<td>Insignificant – Moderate</td>
<td>Possible</td>
<td>Low - High</td>
<td>Some Panel members rated the consequence/impact as moderate because they felt that if the pharmacist didn’t deliver the medicines, the patient wouldn’t have been able to take them, ultimately affecting symptom control. However, others rated the consequence/impact as insignificant/minor because they believed that the pharmacist carried out a role which is a part of routine care, which if wasn’t done, may not have had negative consequences provided someone else was able to collect the medicines. One member was concerned that the issue described in intervention 14 hadn’t yet been resolved (same patient &amp; pharmacist).</td>
</tr>
<tr>
<td>17</td>
<td>Test</td>
<td>Insignificant – Moderate</td>
<td>Possible - Likely</td>
<td>Low - High</td>
<td>As for intervention 16 (same patient &amp; pharmacist) for the delivery of the Pramin by the pharmacist. The Panel felt that the verbal counselling given by the pharmacist with regards to how to take the Pramin was also a part of routine care rather than an intervention.</td>
</tr>
</tbody>
</table>
### Appendix AO: Interventions identified by the Expert Review Panel for which there was insufficient detail available – Issues and resolutions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Issue associated with intervention for which there was insufficient detail available</th>
<th>Response provided by pharmacist to resolve the issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Test</td>
<td>Why was there a disparity between the date of the intervention and the medication history (the patient was on MS Contin at that time, however, the history indicated that Oxycontin was being taken)?</td>
<td>The patient was on MS Contin 10mg &amp; 30mg up until the 28/2/05, after which Oxycontin was newly started. As the Panel were not provided with the medication history before the 14/2/05, they were unaware that the patient was actually on MS Contin, which was last dispensed on the 9/2/05. Thus, there was no disparity between the date of the intervention (18/2/05) and the medication history i.e. the patient was on MS Contin only.</td>
</tr>
<tr>
<td>5</td>
<td>Test</td>
<td>Did the pharmacist ring the GP to inform them of their recommendation, or to discuss the matter further? Who suggested Durolax suppositories as an alternative (pharmacist/GP)?</td>
<td>The pharmacist rang the GP but they were unavailable. The pharmacist therefore suggested Durolax suppositories - they felt that this would be the best alternative for the patient.</td>
</tr>
<tr>
<td>6</td>
<td>Test</td>
<td>Why was there a disparity between the date of the intervention and the medication history (the patient asked the pharmacist if they should complete taking MS Contin and then start taking Oxycontin, however, the history indicated that MS Contin was not being taken at that time)?</td>
<td>As for intervention 2. Thus, there was no disparity between the date of the intervention (28/2/05) and the medication history i.e. the patient wanted to know if they needed to finish taking the MS Contin (old) before starting the Oxycontin (new).</td>
</tr>
<tr>
<td>8</td>
<td>Control</td>
<td>Had the patient taken Ordine mixture before (not indicated by medication history)?</td>
<td>The medication history did indicate that the patient had taken Ordine mixture before (on the 4/8/04 &amp; 5/1/05).</td>
</tr>
<tr>
<td>9</td>
<td>Control</td>
<td>Had the patient taken Rivotril before (not indicated by medication history)?</td>
<td>The patient had taken Rivotril before, in hospital.</td>
</tr>
</tbody>
</table>
Appendix AO continued: Interventions identified by the Expert Review Panel for which there was insufficient detail available – Issues and resolutions

<table>
<thead>
<tr>
<th>Intervention No.</th>
<th>Group</th>
<th>Issue associated with intervention for which there was insufficient detail available</th>
<th>Response provided by pharmacist to resolve the issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Control</td>
<td>Was the patient taking one (50 mcg/hr) or both strengths (50 &amp; 100 mcg/hr) of the Durogesic patch, and was there was a prescription supplied?</td>
<td>Don’t know if the patient was taking both strengths of the Durogesic patch. A prescription was not supplied.</td>
</tr>
<tr>
<td>11</td>
<td>Test</td>
<td>What were the patient’s exact symptoms? Did they continue to be constipated with no bowel motions, and for what duration?</td>
<td>The Durolax suppositories that were previously suggested helped the patient for a while (they had bowel motions). The patient became constipated again (can’t remember duration), for which Coloxxyl &amp; Senna was recommended.</td>
</tr>
<tr>
<td>14</td>
<td>Test</td>
<td>What prompted the pharmacist to counsel the patient about their medicines (Diabex &amp; Diamicron), and what was advised?</td>
<td>The patient told the pharmacist that they take 1 tablet of the Diamicron MR daily, instead of 1 bd prescribed by the GP, because they were eating less (don’t know if this was change was made with/without knowledge of the GP). The pharmacist advised the patient that this was appropriate, and to take the Diamicron MR with the largest size meal of the day.</td>
</tr>
</tbody>
</table>
### Appendix AP: Participants’ medication knowledge and recall of medical information

<table>
<thead>
<tr>
<th>MEDICATION KNOWLEDGE AND RECALL OF MEDICAL INFORMATION</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of medicines taken by patient</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Device used to manage medicines?</td>
<td>No</td>
</tr>
<tr>
<td>Identified names &amp; uses of medicines correctly?</td>
<td>Yes</td>
</tr>
<tr>
<td>Experienced unwanted effects from medicines?</td>
<td>Yes</td>
</tr>
<tr>
<td>Description of unwanted effect(s)</td>
<td>Constipation</td>
</tr>
<tr>
<td>Hot &amp; cold sweats</td>
<td>Hot &amp; cold sweats</td>
</tr>
<tr>
<td>Contacted pharmacist for advice?</td>
<td>Constipation</td>
</tr>
</tbody>
</table>
### Appendix AP continued: Participants’ medication knowledge and recall of medical information

<table>
<thead>
<tr>
<th>MEDICATION KNOWLEDGE AND RECALL OF MEDICAL INFORMATION</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Advice given by pharmacist</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Usefulness of pharmacist’s advice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Change made to medicines in the last 3 months?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Not taken a medicine prescribed by the doctor in the last 3 months?</td>
<td>No</td>
</tr>
</tbody>
</table>
## Appendix AQ: Participants’ view of their interaction with the pharmacist

<table>
<thead>
<tr>
<th>INTERACTION WITH THE PHARMACIST</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Rating* of interaction</td>
<td>10</td>
</tr>
<tr>
<td><strong>Type of information provided</strong></td>
<td>Explanation of medicines</td>
</tr>
<tr>
<td></td>
<td>Communication with other health professionals regarding the patient’s condition and/or medication management</td>
</tr>
<tr>
<td><strong>Format of information provided</strong></td>
<td>Verbal &amp; written</td>
</tr>
<tr>
<td><em><em>Rating</em> of value of information provided</em>*</td>
<td>6 – because majority of the time the shop assistants handed out medicines, and the pharmacist provided information only when requested</td>
</tr>
</tbody>
</table>

*11-point Likert-type scale used (0 = very poor to 10 = excellent)
### Appendix AQ continued: Participants’ view of their interaction with the pharmacist

<table>
<thead>
<tr>
<th>INTERACTION WITH THE PHARMACIST</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Rating* of interaction</td>
<td>10</td>
</tr>
<tr>
<td>Did the pharmacist help improve the patient’s quality of life?</td>
<td>Yes</td>
</tr>
<tr>
<td>Ways in which pharmacist helped improve the patient’s quality of life</td>
<td>Contributing to better symptom control</td>
</tr>
<tr>
<td></td>
<td>Taking the time to answer questions</td>
</tr>
<tr>
<td></td>
<td>Supplying medicines when needed</td>
</tr>
<tr>
<td></td>
<td>Delivering medicines to the home</td>
</tr>
<tr>
<td>Suggestions made for how the pharmacist can improve their interactions</td>
<td>Personally hand out medicines and have a proactive, rather than reactive, approach</td>
</tr>
</tbody>
</table>

*11-point Likert-type scale used (0 = very poor to 10 = excellent)
### Appendix AR: Additional comments made by participants

<table>
<thead>
<tr>
<th>ADDITIONAL COMMENTS</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist was always helpful when asked for advice, and never made us feel like we’re a “nuisance.” It’s up to the consumer to seek information and help - it’s not just the pharmacist’s responsibility.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>It’s up to the consumer to seek information and help - it’s not just the pharmacist’s responsibility</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Pharmacists in general should provide more information on medicines and their side effects</td>
</tr>
<tr>
<td></td>
<td>Everyone at the pharmacy is “very helpful.”</td>
</tr>
</tbody>
</table>
Appendix AS: Interventions made by pharmacists with patients/carers who completed the questionnaires

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
| None made because the patient and/or carer didn’t visit the pharmacy frequently, and because there was no need to intervene. However, the medication history forwarded by the pharmacist indicated that the patient/carer was visiting the pharmacy frequently. | As for questionnaire 1 | As for questionnaire 1; medication history confirmed that the patient wasn’t visiting the pharmacy frequently. However, the pharmacist continued monitoring the patient throughout the study:  
“*The patient is experiencing less nausea associated with chemotherapy than previous treatments and hence is happy about that.*”  
“The patient participated in a hair and makeup clinic at Peter MacCallum Cancer Centre and found the support associated with this interaction with other women in similar circumstances to be of help and comfort.”  
“I confirmed the palliative care nurse’s recommendation to take the second course of an antibiotic prescribed for the patient; under the circumstances I felt that this would be the correct thing to do.” | As for questionnaire 1; medication history confirmed that the patient wasn’t visiting the pharmacy frequently. | The pharmacist made one intervention (Refer to intervention 12, described in Section 5.3.1).  
Even though the patient visited the pharmacy frequently (indicated by medication history forwarded), the pharmacist didn’t make any further interventions because the patient was happy with everything. |
Appendix AT: Was the program beneficial?

The questions for this section, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale.

**Questions 1 to 3 - Benefit of the program**

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1a</td>
<td>My level of knowledge related to palliative cancer care has increased.</td>
</tr>
<tr>
<td>Q1b</td>
<td>I am better able to contribute to the management of palliative cancer care patients.</td>
</tr>
<tr>
<td>Q1c</td>
<td>There has been an increase in the frequency of pharmacist-initiated changes in drug therapy for palliative cancer care patients.</td>
</tr>
<tr>
<td>Q2</td>
<td>The subject material increased my understanding of the potential role of community pharmacists in palliative cancer care.</td>
</tr>
<tr>
<td>Q3</td>
<td>The subject material increased my understanding of the roles of other people involved in palliative care.</td>
</tr>
</tbody>
</table>

**Summary statistics – Questions 1 to 3**

<table>
<thead>
<tr>
<th></th>
<th>Q1a</th>
<th>Q1b</th>
<th>Q1c</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>7.2</td>
<td>7</td>
</tr>
<tr>
<td>Median</td>
<td>8.5</td>
<td>8.5</td>
<td>6</td>
<td>8.5</td>
<td>8</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>9.8</td>
<td>9.8</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Max</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Mean</td>
<td>8.5</td>
<td>8.5</td>
<td>5.5</td>
<td>8.2</td>
<td>8</td>
</tr>
</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AT continued: Was the program beneficial?

Box and Whisker plot: Was the program beneficial?

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first ‘hinge’. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AU: Did the web site assist pharmacists’ learning?

The questions for this section, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale. In addition, question 4 and 7 provided space for additional comments (See Appendix AJ).

Questions 4 to 7 – Web site assisting learning

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4</td>
<td>The website was easy to navigate.</td>
</tr>
<tr>
<td>Q5</td>
<td>The instructions contained within the program were adequate to direct my study of the subject material.</td>
</tr>
<tr>
<td>Q6</td>
<td>The links were useful to assist my learning.</td>
</tr>
<tr>
<td>Q7</td>
<td>The links were distracting.</td>
</tr>
</tbody>
</table>

Summary statistics – Questions 4 to 7

<table>
<thead>
<tr>
<th></th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>6.2</td>
<td>7.2</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Median</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Max</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Mean</td>
<td>7.7</td>
<td>8</td>
<td>8</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AU continued: Did the website assist pharmacists’ learning?

Box and Whisker plot: Did the website assist learning?

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first ‘hinge’. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AV: Engagement with the program material – Subject format

The questions related to familiarity with the program material and critical reflection, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale. In addition, questions 8 and 10 provided space for additional comments (See Appendix AJ).

Questions 8 to 10 – Subject format

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8</td>
<td>The subject material was generally new to me.</td>
</tr>
<tr>
<td>Q9</td>
<td>The format of the subject material encouraged me to critically reflect upon what I was learning.</td>
</tr>
<tr>
<td>Q10</td>
<td>The format of the subject material encouraged me to analyse my own clinical practice.</td>
</tr>
</tbody>
</table>

Summary statistics – Questions 8 to 10

<table>
<thead>
<tr>
<th></th>
<th>Q8</th>
<th>Q9</th>
<th>Q10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Median</td>
<td>6</td>
<td>7.5</td>
<td>8</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Max</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Mean</td>
<td>5.9</td>
<td>7.5</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AV continued: Engagement with the program material – Subject format

Box and Whisker plot: Subject format

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first ‘hinge’. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AW: Program design aspects assisting engagement with the material

The questions related to the program design, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale.

Questions 11 to 15 – Program design aspects assisting engagement with the material

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11</td>
<td>I used the Key Messages at the beginning of each Module to look for the topics I wanted to study.</td>
</tr>
<tr>
<td>Q12</td>
<td>The Case Studies were useful in assisting my learning.</td>
</tr>
<tr>
<td>Q13</td>
<td>The Activities in the program provided relevant learning experiences.</td>
</tr>
<tr>
<td>Q14</td>
<td>The Activities and Answers to the Activities enabled me to monitor my progress in learning the subject material.</td>
</tr>
<tr>
<td>Q15</td>
<td>The Practice Points enabled me to learn the most important points for clinical practice.</td>
</tr>
</tbody>
</table>

Summary statistics – Questions 11 to 15

<table>
<thead>
<tr>
<th></th>
<th>Q11</th>
<th>Q12</th>
<th>Q13</th>
<th>Q14</th>
<th>Q15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>1.2</td>
<td>7</td>
<td>7</td>
<td>6.2</td>
<td>7</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>8.5</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>8.8</td>
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<tr>
<td>Max</td>
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<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Mean</td>
<td>4.5</td>
<td>8.1</td>
<td>7.6</td>
<td>7.8</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AW continued: Program design aspects assisting engagement with the material

Box and Whisker plot: Design aspects assisting with learning

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first 'hinge'. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AX: Interactive activities

The questions related to the interactive activities (Notice Board and Discussion Group), along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale. In addition, a space was provided for additional comments for question 17.

Questions 16 to 18 – Interactive activities

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
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</thead>
<tbody>
<tr>
<td>Q16</td>
<td>The Notice Board helped me to compare my own knowledge of palliative cancer care with that of other pharmacists.</td>
</tr>
<tr>
<td>Q17</td>
<td>The Discussion Group helped me to network with other pharmacists and specialists about palliative care issues.</td>
</tr>
<tr>
<td>Q18</td>
<td>The Discussion Group helped me to learn more about palliative cancer care.</td>
</tr>
</tbody>
</table>

Summary statistics – Questions 16 to 18

<table>
<thead>
<tr>
<th></th>
<th>Q16</th>
<th>Q17</th>
<th>Q18</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>25th Percentile</td>
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<td>1</td>
</tr>
<tr>
<td>Median</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>75th Percentile</td>
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<td>7</td>
</tr>
<tr>
<td>Max</td>
<td>10</td>
<td>9</td>
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<td>Mean</td>
<td>7</td>
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<td>3.7</td>
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</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AX continued: Interactive activities

Box and Whisker plot: Engagement with the interactive activities

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first ‘hinge’. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AY: Which modules were useful and which were not?

The questions related to the participants’ opinions regarding the usefulness of each of the modules, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale.

**Question 20 – a) through to k) – Usefulness of the modules**

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
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<tbody>
<tr>
<td>Mod 1</td>
<td>Module 1: Getting the most from the program</td>
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<tr>
<td>Mod 2</td>
<td>Module 2: Introduction – Principles of palliative cancer care</td>
</tr>
<tr>
<td>Mod 3</td>
<td>Module 3: Management of cancer pain</td>
</tr>
<tr>
<td>Mod 4</td>
<td>Module 4: Management of non-pain symptoms and side effects of treatment</td>
</tr>
<tr>
<td>Mod 5</td>
<td>Module 5: Complementary and alternative medicines used by patients with cancer</td>
</tr>
<tr>
<td>Mod 6</td>
<td>Module 6: Methods of medication administration</td>
</tr>
<tr>
<td>Mod 7</td>
<td>Module 7: Access to palliative cancer care medicines</td>
</tr>
<tr>
<td>Mod 8</td>
<td>Module 8: Psycho-social care</td>
</tr>
<tr>
<td>Mod 9</td>
<td>Module 9: Communication with patients, carers and families</td>
</tr>
<tr>
<td>Mod 10</td>
<td>Module 10: Ethical issue</td>
</tr>
<tr>
<td>Mod 11</td>
<td>Module 11: Working in partnership to enhance patient care</td>
</tr>
</tbody>
</table>

**Summary statistics – Question 20 a) – k)**

<table>
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<tr>
<th></th>
<th>Mod 1</th>
<th>Mod 2</th>
<th>Mod 3</th>
<th>Mod 4</th>
<th>Mod 5</th>
<th>Mod 6</th>
<th>Mod 7</th>
<th>Mod 8</th>
<th>Mod 9</th>
<th>Mod 10</th>
<th>Mod 11</th>
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<td>5</td>
<td>7</td>
<td>6</td>
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<td>5</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
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<td>8</td>
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<td>8</td>
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</tr>
<tr>
<td>75th Percentile</td>
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<td>8.3</td>
<td>7.7</td>
<td>7.4</td>
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</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AY: Which modules were useful and which were not?

Box and Whisker plot: Usefulness of the program modules

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first 'hinge'. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: "o"
Appendix AZ: Did pharmacists’ consultation with others increase from doing the program?

The questions related to whether pharmacists’ consultation or collaboration with others had increased from doing the program, along with the summary statistics, are presented below. All questions were rated using the eleven-point Likert scale. In addition, question 21 provided a space for participants to state any other people they may have consulted with (See Appendix AJ).

Other people consulted as a result of doing the program

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharm</td>
<td>Other pharmacists</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioners</td>
</tr>
<tr>
<td>Nurses</td>
<td>Nurses</td>
</tr>
<tr>
<td>Pat hosp</td>
<td>Patients’ hospital</td>
</tr>
<tr>
<td>Pat</td>
<td>Patients</td>
</tr>
<tr>
<td>Carer</td>
<td>Carers</td>
</tr>
<tr>
<td>No-one</td>
<td>I consulted with no-one else</td>
</tr>
<tr>
<td>Oth</td>
<td>Others</td>
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</tbody>
</table>

Summary statistics – Question 21 a) to g)

<table>
<thead>
<tr>
<th></th>
<th>Pharm</th>
<th>GP</th>
<th>Nurses</th>
<th>Patients’ Hospital</th>
<th>Patient</th>
<th>Carers</th>
<th>No-one</th>
</tr>
</thead>
<tbody>
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<td>6.9</td>
<td>4.2</td>
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</tbody>
</table>

Summary statistics are further illustrated in the Box-and-Whisker plot below.
Appendix AZ continued: Did pharmacists’ consultation with others increase from doing the program?

Box and Whisker plot: Degree of consultation/collaboration with others

- The five number summary; minimum, 25th percentile, median (50th percentile), 75th percentile, and the maximum, provides information of the location and spread of the responses.
- Box-and-Whisker plots have been used to illustrate the responses and the spread of the responses given by participants.
- The minimum is identified by the smallest pictured value on the Box-and-Whisker plots. The 25th percentile is identified by the first ‘hinge’. The 75th percentile is denoted by the upper hinge.
- The median indicated the middle value (location), and is indicated by a marker located between the 25th and 75th percentile.
- The Evaluation Test Group pharmacists’ responses (n = 4) have been indicated by dots.
- Outliers have been indicated by a circle: “o