Pharmaceutical Care Principles and Processes
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Preventable injury and death resulting from routine drug therapy is well documented by published research. Weaknesses in the environment, structure and process of medications use have been proposed as causes of preventable drug-related morbidity or mortality (PDRM). These include:

- professionals’ general pharmacologic knowledge & access to information
- time availability
- interruptions
- access to patient-specific data
- professionals’ understanding of practice roles
- commercial concerns
- economic & geographic barriers
- inconsistent and ineffective prescribing influences (formularies, etc.)

Certain process failures and drug therapy problems repeatedly were implicated in published studies as causes of PDRM:

- inappropriate prescribing
- patient noncompliance
- overdose or underdose, either in general or for a specific patient
- lack of a necessary drug therapy
- failure to recognize symptoms of disease or early signs of adverse drug reactions, toxicity, treatment failure, etc.;
- delay in response, inadequate follow up of clinical signs and symptoms
- medication error

In response to this information, I wanted to describe a system that could avoid such process failures. Since a system is multi-dimensional and dynamic, it has to be described in many different ways. This article, describes it as a set of general principles and then as a process.

Principles of Pharmaceutical Care

Based on the literature mentioned above, most instances of PDRM could theoretically be prevented if medications use systems followed five principles. These are evidently not widely implemented. If they seem obvious to you, I suggest that you use them as a kind of checklist for reviewing and assessing the quality of a particular drug therapy process or system with which you are familiar.
1. **Patients need timely & accurate responses to signs and symptoms.** First, patients need timely and accurate responses to their basic medical problems by the initiator (physician, nurse practitioner, etc.) We may call this a diagnosis followed by a treatment plan, but all that is really needed is that the initiator have an accurate, clear clinical impression followed by an order for therapy.

The "right drug" (as in the sense of “drug of choice”) for the wrong indication will not improve a patient’s clinical condition or quality of life. Others involved in drug therapy often should defer to the physician’s diagnostic expertise. However, pharmacists, nurses, and patients may recognize problems related to undiagnosed disease, untreated indications, or may see evidence that might change a diagnosis.

For pharmacists and other cotherapists, this principle would most frequently refer to detecting and resolving drug therapy problems. Pharmacist, patient and physician each may have an essential part. This point is related to the “cooperation” principle, below.

2. **Patients need access to safe & cost-effective medications** This seems pretty obvious, and access seems pretty straightforward, but it may not be. There are at least six levels at which access to medications can be restricted: national drug license laws; finances, including insurance provisions and formulary inclusions; prescribing; inventory availability; dispensing; and use by the patient (including bioavailability).

- National drug licensing decisions (marketing controls) are part of the environment of a medications use system. These are beyond a professional’s control in the treatment of a particular patient. I’m including them here for completeness. Nonetheless, sometimes a so-called orphan drug, custom-compounded prescription, or a drug licensed for use in another country might be just what a patient needs.

- Some patients cannot afford to pay for (or share the cost of) the medications they need. A formulary may discourage a patient’s getting the medicine that the doctor would prefer, or even deny any prescription beyond coverage limits. A professional should be alert to problems involving formulary availability, prescription limits and exclusions, etc. Many of these can be resolved, one way or another.

- Under-prescribing may be as important as over-prescribing in influencing the overall cost and effectiveness of medications use. The needs of the patient should determine what is appropriate prescribing, so appropriate prescribing may vary from case to case. Even if two cases seem similar, they may differ in important respects. As obvious as this may seem, relatively few “prescribing review” programs are sensitive to problems such as failure to prescribe for a valid indication. Untreated pain, for example, remains a common and significant problem.

- A pharmacy must stock the medicine. This sounds obvious, but some pharmacies don’t stock certain drug products that are expensive, unusual, or attractive to thieves. Some alternative source or arrangement has to be offered to the patient.
• Correct dispensing requires more than a correctly filled prescription. In addition, when
the patient or family caregiver leaves the pharmacy, he should . . .
  • have received the medicine, with any necessary administration equipment, e.g.,
    syringe and needles
  • know how to use the medications and administration equipment properly,
  • know how to recognize key events (therapeutic success, therapeutic failure,
    emergence of adverse effects) and what to do if they appear (or fail to appear)
  • have consented to the therapy and accepted the necessity of cooperating in its use

• Access problems during therapy involve a patient’s actually following the directions for
  use. Sometimes, for example with inhaled or injected medication, the patient may be
  administering it ineffectively. In addition, interactions between medications and foods can
  sometimes prevent the medication from being absorbed normally. The point is that a
  patient who is not having the expected effect of drug therapy might be trying to comply
  but not actually be getting the drug because of a problem with administration and
  absorption. It is worse than useless to assume that such a patient is intentionally non-
  compliant.

3. Patients Need Planned, Professional, Follow-up This principle is closely related to Principle
   1 (responsiveness). It emphasizes the need for planned, continual, monitoring throughout therapy.
   Systematic detection and response to drug therapy problems may be the most important area of
   possible improvement in medications use. Two levels of monitoring are necessary: facilitator
   (patient) and co-therapist (professional).

   Patient self-monitoring mainly involves facts about what is happening during therapy.
   Sometimes the patient can correctly interpret information and appropriately correct therapy. An
   example of this would be “sliding scale” insulin dosage based on self-administered blood glucose
determinations. Sometimes a patient should keep a diary to help him report facts to a caregiver.

   In addition, drug therapy monitoring often requires professional judgement to interpret facts.
   For example, a patient may attribute dizziness to old age or fatigue when it may be a side effect
   that could develop into an DRM. Very briefly, pharmacists, nurses or physicians should address
   the following three questions for each new and repeat prescription:

   • is the patient actually getting the necessary medication (this includes correct use of
     the product and associated devices)
   • is the patient receiving the expected therapeutic effect in the expected or appropriate
     time interval?
   • is the patient experiencing any adverse effects such as toxicity, side effect, adverse
     reaction?

   Explicit therapeutic objectives should direct medications use. They are prerequisites to
   monitoring and patient participation in care. They provide the standard for judging the progress of
   therapy. Explicit objectives make these comparisons and judgements much more precise.

4. Patients Need Cooperation With and Among Health Professionals As with monitoring, two
levels of cooperation can be discerned.

Patient participation in care. Outcomes of drug therapy may be unpredictable, and in some cases may depend on patients' beliefs, at least insofar as beliefs influence a patient’s medication-taking behavior. Patients would often be in the best position to notice evidence that a therapy was or was not reaching the therapeutic objective. (See Principle 3 above.) Therefore professionals often need active cooperation by patients, especially for therapies that require close monitoring. The condition for full participation in care has been called concordance, which is, in effect, informed consent to therapy. This does not mean that patients should be asked to sign consent forms – it means that a patient or family caregiver should understand and agree to the therapy.

Interprofessional cooperation. The new roles in a pharmaceutical care system are not well recognized and may create ambiguity about “who does what.” Cooperation among professionals, especially when roles are not well-established, can be facilitated by explicit communications and written referrals. When referrals become frequent, they can be replaced by protocols and collaborative practice agreements. For example, a physician may authorize a pharmacist to order INRs or blood levels and to change doses within limits based on lab tests or patient responses.

To maintain coordination, professionals should document care decisions and actions and communicate them. Care given but not documented may sometimes harm the patient, e.g., if it leads to mis-diagnosis or therapeutic duplication. The separate practice locations of community pharmacists and community physicians can be a problem, but it can be overcome by means of collaborative agreements and electronic communications.

5. Patients Need Medications Use Systems. The necessary processes of drug therapy should be organized into a system in which processes and relationships can occur consistently and predictably. These processes should be managed as a system. A medications use system comprises two subsystems: pharmaceutical care systems (PCS) on the clinical level and medications management systems (MMS) on the practice and program level.

In a systems approach, many DRM that do not seem preventable by simple solutions become preventable. Some DRM involve over-the-counter medications, e.g., G.I. bleeding from nonsteroidal anti-inflammatory drugs (NSAIDs). This underscores the importance of patient-rather than product-oriented care. Studies show that appropriate cooperative relationships between nurses, physicians and pharmacists improve clinical outcomes, often at less total system cost. It also happens that most of the successful attempts to organize drug therapy systems have involved increased pharmacist-physician cooperation.

Unfortunately, we don’t know enough yet about exactly how to design and operate a pharmaceutical care system in all environments. Therefore, they require regular performance assessment through a MMS.

A Systematic Process for Pharmaceutical Care (Medication Therapy Management)
Effective drug therapy requires three overlapping functions: *initiation of therapy*, which is prescribing based on medical problem assessment; professional *supervision of therapy* by the prescriber or a co-therapist (e.g., pharmacist, nurse or physicians’ assistant) and *facilitation of therapy*, (including drug administration) e.g., by the patient himself, a family caregiver, nurse, etc.

This section describes the functions of a professional co-therapist in a pharmaceutical care (Pharmaceutical care) or Medication Therapy Management (MTM) system, namely cooperation with patients (and other therapy facilitators) and physicians (or other therapy initiators) in supervising the progress of drug therapy. Nurses, physicians, and physicians’ assistants all can function as co-therapists. However, pharmacists are the best educated in pharmacology and therapeutics and are well-placed in medications use processes. This is the pharmacist’s greatest potential contribution in a pharmaceutical care system.

There are at least two prerequisites for a co-therapist to function effectively:

1. **A cooperative relationship among all participants.** Cooperation requires communication and is greatly facilitated by shared goals, trust, and respect. At least, each participant should understand the cooperative intent and overall goal of the pharmacist’s involvement. The most direct ways for a pharmacist to obtain cooperation is to offer his services to both patients and physicians, e.g., by entering into a cooperative practice agreement or by requesting patient referrals.

   Some pharmacists seem to prefer a more informal approach, “stealth” pharmacy, in which they may simply begin a new practice. However, when patients or physicians notice that the pharmacist is becoming more involved in drug therapy management, they may misunderstand what the pharmacist is doing, and why. For example, a patient may interpret the pharmacist’s unusual interest as a sign that something is wrong with his prescriptions. A physician may become defensive because the pharmacist is asking so many new questions.

2. **Basic information about the patient.** In cooperating practices, patient information may be available through shared medical records or computer linkages. Otherwise, the main source may be a patient history taken within the pharmacy practice.

Figure 1 shows the functions of a pharmaceutical care system. Prescriber (initiator) functions are shown across the top of the figure. The prescriber recognizes a patient problem, assesses it, forms a clinical impression, and develops a therapeutic plan. (This is the familiar S-O-A-P process of problem-oriented practice.)

The functions of the pharmacist or other co-therapist are numbered 1-8, and are described in detail below. This practice model is based on the Therapeutic Outcomes Monitoring project developed at the University of Florida. It is a cycle in which information is repeatedly acquired, analyzed, and used as the basis of decisions and actions. Cipolle, et al have described another,
similar model in more detail.\textsuperscript{10}

The steps can be carried out by a pharmacist or by a physician-pharmacist-nurse team, with assistance from aides, etc. Who carries out each step is less important than ensuring that all eight steps are done, in order, during each cycle of care.

Although the steps of care should be carried out in order, the process of patient assessment requires professional dialog.

Dialog with a patient cannot be strictly stepwise. The dialog may cycle back to an earlier step based on new information. For example, it may happen that a pharmacist learns about a new DTP at step 5, while advising a patient. Naturally, she would cycle back through steps 1-4 to work up this new problem, before completing step 5.

Also, the pharmacist might spend a different amount of time on a given step, depending on the stage of care. For example, step 1 would require significantly more time for a new patient than for a continuing patient, and more time for a new regimen than for continuation of a stable regimen. However, at least a brief review of each step is necessary at each cycle. This is described further below, under documentation.

The description that follows may seem more complicated than the system really is in practice. I have tried to be fairly complete, and have included some actions that many pharmacist already do for some patients. After a pharmacist learns the basics and practices a few times to develop some facility with them, the practice is really straightforward. For many patients who are continuing therapy, steps 1-4 take little time, and the cycle is essentially the three steps shown in Table 2.

1. **Record and interpret relevant patient information.**
   **What do we need to know about this patient?**

The objective of this step is, at least, to have a problem list, including allergies and major events involving medicines. In cooperating practices, or when a patient requests it, the problem list can be obtained from the patient's primary physician. Also, the patient or family caregiver often can provide basic information by completing a questionnaire. The pharmacy’s prescription profile is also a necessary part of this record but may require updating with information about OTC medicines and prescription medicines that were purchased elsewhere. The pharmacist may need to go further into some questions depending on circumstances.

In particular, the patient’s medical and psychosocial status and current medication profile can provide a clinical impression of past and present medications use and may suggest the need for additional information about the patient. This may lead to finding some untreated indications and some unnecessary medications.
The emphasis of pharmaceutical care on patient outcomes starts here. One of the first things to find out is what the patient wants to achieve through care or treatment. In contrast, a drug-oriented “profile review”, even though it may seem similar in function, lacks the orientation to patient outcome and, for example, may miss untreated medical problems.

The co-therapist should understand systems on the level of individual patients. This sounds difficult, but it can actually be quite straightforward. A health professional can understand a patient’s care system as easily as she can understand a patient’s physiological system, if she knows what to look for and how to organize her thinking. A good way to understand a patient's specific system of care would be to review the five principles of medications use described above.

2. Document Therapeutic Plan and Desired Therapeutic Objectives for the Patient.
What do we intend to achieve with this therapy in this patient?

Explicit clinical and quality-of-life objectives of each drug in the regimen will be necessary as a partial basis for evaluating patient progress. To be useful, therapeutic objectives must be clear and attainable. Sometimes, they will be obvious. For example, symptom remission would be the immediate therapeutic objective of an antibiotic prescribed for a urinary tract infection (an intermediate objective on the way to curing the infection). At other times, the pharmacist may need to ask the prescriber about clinical objectives and the patient about psychosocial objectives.

However, even obvious objectives may be vague in some respects. For example, when the pharmacist is developing a monitoring plan (step 4), she may need to decide a specific time period, e.g., 36 hours, within which she should expect UTI symptoms to resolve, if therapy is ultimately to achieve a cure.

3. Evaluate Therapeutic Plan.
Is this an acceptable plan to achieve those objectives for this patient?

This step gets particular attention during review of new therapy. For therapy-in-progress, the questions in step 6 may be more useful. The objective is to reconcile the therapeutic plan with the therapeutic objectives, rather than to produce a standard therapeutic plan or to conform with “drugs of choice.” The pharmacist discusses any questions about the therapeutic plan with the prescriber, as shown by the feedback loop drawn from Step 3 in the figure.

3.1 Review Potential Drug therapy problems.

A systematic and useful means for evaluating a new prescription or other change in a therapeutic plan is to consider categories of potential drug therapy problems (DTP’s). See Table 1.

3.1.1. Is there legitimate medical or psychosocial justification for the regimen? Is the therapeutic objective sufficiently clear?

It is logically impossible to judge the suitability of a regimen without reference to the indication (problem list) and therapeutic objective. Also, a clear therapeutic objective will facilitate managing therapy.
3.1.2. Is the medicine appropriate for the patient’s clinical and psychosocial objectives, and psychosocial circumstances?

- Has an appropriate medicine been prescribed in a potentially inappropriate dosage, frequency, route or regimen?
- Is there reason to believe the patient may experience a drug interaction or drug-food incompatibility, or that the regimen may interfere with an essential laboratory test?
- Is there reason to believe that the patient may not actually receive the therapy for economic, psychological or other reasons? For example, perhaps the patient may be unable to afford it, unable to use necessary administration equipment, unable to remember the regimen or unwilling to begin or to continue the regimen.

3.1.3. According to the problem list, does the patient have an (as yet) untreated indication? Might he need additional drug therapy, other forms of therapy or information, e.g., diet.

3.2 Judge the likelihood that the patient would develop one or more DTP’s when following the therapeutic plan and the probable severity of those DTP’s.

Estimating probable severity would depend in part on how readily a potential DTP would be detected and controlled if it were actually to develop. For these judgements to be realistic, moreover, they should be made in the context of the severity of the medical problem and specific therapeutic alternatives.

3.3 Decide whether it is necessary to modify the regimen, and if so, make a recommendation to the prescriber.

3.4 Document major concerns and recommendations.

The minimum outcome of steps 1-3 should be a list of the patient's medical problems, an idea of how his current medications address those problems, and the therapeutic objective for each therapy, including what the patient wants to get from therapy.

4. Design a Monitoring Plan.
What evidence will we need to assess progress of therapy?

The objective is to develop a simple, written plan to collect necessary information at some future time. The information would be used to evaluate patient progress toward therapeutic objectives.

4.1 Decide what information to collect about the progress of the patient’s drug therapy, when and how to collect it.

The evaluation of therapy carried out in step 3 is one basis for these decisions. Another useful
basis is a standard protocol for managing a particular disease state or drug therapy, especially clinical indicators of the status of therapy.

4.2 If necessary, arrange for follow up visit or telephone call. (See also 5.3, below)

4.3 Document the monitoring plan in the patient’s record and in a calendar.


Can this patient (or family caregiver, etc.) now make the best use of this medicine?

5.1 Decide to whom, when and how you will dispense the medicine.

In some cases, e.g., new prescriptions requiring use of administration devices, an educational dialogue with the patient may be necessary. This requires that the patient be willing and able to have that dialog. If the patient is tired or in a hurry, (or the pharmacist is pressed for time) it may be necessary to arrange a more favorable time.

5.2 Provide effective patient education.

Patient advising should be done with the objective of recruiting and empowering the patient or family caregiver as a therapeutic partner. That is, the patient ideally should be able to address five points:

• how he should use the medicine, e.g., demonstrate the use of administration devices, when appropriate.
• how he can recognize when therapy is succeeding,
• how he can recognize major problems
• what he should do if they occur.

5.3 Discuss roles and responsibilities

In pharmaceutical care, the patient actively cooperates in his own care and the pharmacist monitors outcomes more carefully. This step should include, when appropriate, some discussion of what the patient and pharmacist should expect each other to do, for example, when the pharmacist will call the patient according to the monitoring plan and what she will want to know; when the patient should call the pharmacist or physician for help.

5.4 Document the discussion.

6. Implement the Monitoring Plan.

What evidence do I need to assist in evaluating this patient's progress?

Information about actual problems is needed in three general areas (see Table 2):

6.1 Access and adherence: Is the patient actually receiving the medicine as intended? Does the
patient intend to continue? Can the patient describe how she takes the medicines? Can she
demonstrate the use of administration devices?

6.2 Effectiveness: Is there evidence that the medicine is having the desired effect relative to the
original therapeutic objective? Does the patient feel better? Is the patient able to function better?

6.3 Safety: Is there evidence that the medicine is causing a new medical problem or interfering
with necessary or desired activities of life, e.g., morning drowsiness from CNS drugs.

Comment. Implementing the monitoring plan can be as simple as telephoning a patient. It may
require the patient's visiting the pharmacy for more extensive interview. Some of the information
obtained should be based on the specific regimen, therapeutic objectives or patient circum-
stances.

7. Identify Possible Drug Therapy Problems.
Is this patient progressing toward therapeutic objectives? Are there indicators of drug
therapy problems?

The pharmacist may have begun this step while interpreting responses to his follow-up questions
in step 6. For some of the actual problems identified in Step 6, the pharmacist needs to consider
potential DTP’s as the possible root causes.

8. Respond to Problems.
What action should I take now?

The disposition of any identified drug therapy problem depends, among other things, on the
nature of the problem and the pharmacists’s competence and professional relationships.

8.1 Refer

8.1.1 Refer without recommendation. The pharmacist can call the evidence of a problem to the
patient’s or prescriber’s attention. This might be a good choice if the pharmacist has noted a
serious medical problem without a potential DTP or if the pharmacist is simply not confident
in making a recommendation.

8.1.2 Refer with recommendation. When possible, the pharmacist can recommend specific
alternative solutions to the prescriber.

8.2 Resolve. The pharmacist could recommend to the patient safer or more effective ways to take
the medicine (e.g., improving inhaler use, taking medicine with food). Depending on the
circumstances this may need to be discussed with the prescriber in advance or the pharmacist may
simply notify the prescriber of the recommendation.

Whether or not therapy were changed, the pharmacist would continue to monitor patient
progress, revise her monitoring plan and report patient progress to the prescriber. This is
essentially a return to step 1.

**NEED FOR A CONSISTENT PROCESS.**

Some pharmacists completed their educations without having learned a consistent process of care. Some have developed their own process, which they prefer to others. There is no convincing research showing that one process is better than another. It is reasonable to ask why each pharmacist cannot be left to practice in his or her own way.

Within a practice group, such as a community pharmacy, too much variety in process has major disadvantages from both the standpoints of practice and practice management. These are easily explained by reference to the ideal of pharmaceutical care:

responsible, cooperative provision of drug therapy for the purpose of achieving definite outcomes intended to improve a patient's quality of life.

1. A consistent process is easier to document correctly. Whichever process is used should promote cooperation, assignment of responsibility for a part of process, and shared responsibility for outcomes. These in turn require documentation. Documentation also improves efficiency by allowing each person to see what has already been accomplished and to add to it, rather than repeating work already done. Efficient documentation is much easier if the process is consistent among the providers.

2. Consistency allows patients and physicians to develop expectations about a practice and then, confidence that the practice will meet those expectations. This may be necessary before they will cooperate and trust the pharmacists with more responsibility.

3. A practice is much easier to manage if the pharmacists all are following a consistent process of patient care and documentation. Consistency allows the manager to develop standards and to develop performance indicators relevant to those standards. This simplifies the job of detecting quality problems in the practice.

4. Patients and third parties may be much more likely to pay for care that consistently meets a standard.

**Summary.** PhC/MTM comprises eight steps performed in a cycle. Steps 1-2 lay a foundation for therapy. Step 3 is a preliminary assessment of the therapeutic plan in the context of therapeutic objectives. In step 5 the cotherapist provides the necessities of therapy (drug products and information) to the patient. Steps 4 and 6 require assessment of progress toward therapeutic objectives and detection of drug-therapy problems. In step 7 the cotherapist decides whether the patient is making acceptable progress and, if not, defines the basic cause of the problem; in step 8 she identifies, evaluates and chooses among alternative solutions and carries them out (essentially resolves or refers the problem). She may continue the cycle with steps 1-3, perhaps briefly considering whether more information is needed and re-considering the therapeutic plan. Then monitoring (steps 6-8) recurs.
Table 1. Classification of Drug Therapy Problems

<table>
<thead>
<tr>
<th>Access</th>
<th>Effectiveness</th>
</tr>
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<tbody>
<tr>
<td>1. The patient has a medical problem that requires drug therapy (a</td>
<td>2. <strong>Wrong drug</strong>. The patient has a drug indication but is taking an ineffective drug for that indication or has a <strong>drug interaction</strong> that diminishes therapeutic effectiveness.</td>
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<td>drug indication) but is <em>not receiving</em> a drug for that indication.</td>
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<tr>
<td>Potential causes:</td>
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<tr>
<td>a. A prescription drug has not been ordered,</td>
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<tr>
<td>— afford it</td>
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<tr>
<td>— accept it</td>
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<tr>
<td>— obtain it</td>
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<tr>
<td>— use administration devices correctly</td>
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<tr>
<td>b. The patient cannot</td>
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<tr>
<td>2. <strong>Wrong Dose</strong>. The patient is being treated with <strong>too little</strong> of</td>
<td></td>
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<tr>
<td>the correct drug.</td>
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<tr>
<td>Potential causes:</td>
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<tr>
<td>— dose ordered is insufficient for patient’s actual need</td>
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<tr>
<td>— low drug bioavailability,</td>
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<tr>
<td>— drug-drug or drug-food interactions</td>
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<tr>
<td>— dispensing or administration error</td>
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<tr>
<td>including patient or caregiver nonadherence</td>
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<tr>
<td>3. <strong>Wrong Dose</strong>. The patient is having an <strong>adverse drug reaction or side effect</strong> to the correct drug</td>
<td></td>
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<tr>
<td>4. <strong>Wrong drug</strong>. the patient is taking an absolutely or relatively contra-indicated drug, including a drug that interacts with another to create an adverse reaction, side effect or toxicity.</td>
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<tr>
<td>5. The patient is having an adverse drug reaction or side effect to the correct drug</td>
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<tr>
<td>6. <strong>Wrong Dose</strong>. the patient has a problem resulting from <strong>too much</strong> of the correct drug (toxicity)</td>
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<tr>
<td>Potential causes:</td>
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<tr>
<td>— dose ordered is excessive for patient’s actual need</td>
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<tr>
<td>— excess drug bio-availability,</td>
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<td>— drug-drug or drug-food interactions</td>
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<td>— dispensing or administration error</td>
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<td>including patient or caregiver nonadherence</td>
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<tr>
<td>7. the patient is taking a drug for no medically valid indication (including inappropriate duplicate therapy)</td>
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<tr>
<td>8. the patient has a problem resulting from a <strong>drug-laboratory interaction</strong> (a real problem obscured or a merely apparent problem.)</td>
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* various verb tenses: may not receive, did not receive, etc.

Table 2. Minimum Followup Questions in Pharmaceutical Care

<table>
<thead>
<tr>
<th>Access</th>
<th>Effectiveness</th>
<th>Safety</th>
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<tbody>
<tr>
<td>6. Is there an actual DTP or a DRM?</td>
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<tr>
<td>7. Is there a potential DTP?</td>
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<td></td>
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<tr>
<td>8. How can we resolve it?</td>
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References


2. Hepler C.D. and Segal R. Loc cit chapters 2-3


