[redacted]

ID No:

This questionnaire should only take you 15 minutes to complete

Your pharmacy visit

IMPORTANT – PLEASE READ

This is a survey about your recent visit to a pharmacy (or "chemist").

We are interested in finding out how you feel about the information you received about your medicines during this visit, how satisfied you were with your visit, and how you usually take your medicines.

Even if you did not receive any information about your medicines *during this visit, we are just as interested in your answers to these questions.*

Please answer the questions ***thinking only about the pharmacy/chemist where you received this questionnaire.***

Everything you say in this questionnaire will remain ***strictly confidential and will not be shared with the pharmacy/chemist.***

PLEASE RETURN TO:

Dr Sally Jacobs

FREEPOST [redacted], **THE UNIVERSITY OF MANCHESTER, MANCHESTER PHARMACY SCHOOL, STOPFORD BUILDING, 1ST FLOOR, OXFORD ROAD, MANCHESTER M13 9PT**

YOUR VISIT TO THE PHARMACY/CHEMIST

- **We would like to ask you some questions about your visit to this pharmacy/ chemist.**
- *Please answer the questions* ***thinking only about the pharmacy/chemist where you received this questionnaire.***

1. **On this occasion, what happened during your visit to the pharmacy/chemist?** *(Please tick* ***all that apply****)*

- ☐ I collected a prescription for myself
- ☐ I collected a prescription for someone else
- ☐ The pharmacist reviewed my medicines with me (a "medicines use review" or "MUR")
- ☐ Other, please specify_____

2. **Which ONE of the following statements best describes how often you use this pharmacy/chemist in relation to your medicines?** *(Please tick* ***ONE*** *box only).*

- ☐ This is the only pharmacy/chemist that I visit
- ☐ This is the pharmacy/chemist I visit most often
- ☐ I do not visit this pharmacy/chemist more often than any other
- ☐ This is the first time I have visited this pharmacy/chemist

3. **Why did you choose to visit this pharmacy/chemist on this occasion?** *(Please tick* ***ALL that apply****)*

- ☐ Convenient location (e.g. close to home, work, shops, GP etc.)
- ☐ Helpful pharmacist/staff
- ☐ Good advice
- ☐ Prompt service
- ☐ Open early or late
- ☐ Parking/easy transport
- ☐ Range of products
- ☐ Competitive prices
- ☐ Loyalty
- ☐ Another reason. *Please specify* _____

SATISFACTION WITH YOUR VISIT

- **We would like to ask you how you feel about your visit to this pharmacy/chemist.**
- *Please answer the questions* ***thinking only about the pharmacy/chemist where you received this questionnaire.***

Please rate how you feel about each of the following aspects of your visit to this pharmacy/chemist by ticking the appropriate box.

4. [redacted]	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicable
[redacted]						

Question taken from: Tinelli, Blenkinsopp, Bond et al. (2011). Development, validation and application of a patient satisfaction scale for a community pharmacy medicines-management service. *Int. J. Pharm. Pract.* **19**: 144-155.

5. Overall, how satisfied are you with your visit to this pharmacy/chemist? *(Please circle one number)*

Very satisfied 5 4 3 2 1 Very dissatisfied

INFORMATION ABOUT MEDICINES

- **We are interested in finding out more about the information or advice you may or may not have received about your medicines during this visit.**

Please think about ALL of your prescription medicines including those in pill or liquid form; eye, ear or nasal drops; medicated creams, lotions or ointments; inhalers; contraceptives; patches; injections; pessaries and suppositories.

6. **How many different medicines are you currently being prescribed?** *(Please tick **ONE** box only).*
   - ☐ 1
   - ☐ 2-3
   - ☐ 4-10
   - ☐ More than 10

7. **Did you receive any of these medicines for the first time during this visit to the pharmacy/ chemist?**
   - ☐ Yes
   - ☐ No

8. **During this visit, did you receive any information or advice about your medicines?**
   - ☐ Yes – Go to Q9
   - ☐ No – Go to Q11
   - ☐ Don't know – Go to Q11

9. **If yes (to Q8), was the information you received:** *(Please tick **ONE** box only).*
   - ☐ Written
   - ☐ Verbal
   - ☐ Both written and verbal

10. **If yes (to Q8), which member of staff did you receive information/advice about your medicines from?** *(Please tick **ONE** box only).*
    - ☐ The pharmacist only
    - ☐ Other pharmacy staff only
    - ☐ Both the pharmacist and other pharmacy staff
    - ☐ Don't know

11. **Do you usually get information/advice about your medicines from the same person in this pharmacy/chemist?**
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Not applicable

- **We would like to ask you some more about the information you may or may not have received about your medicines *during this visit to the pharmacy/chemist*.**
- **If you did not receive any information during your visit, *please still complete this question*, using the 'None received' or 'None needed' options.**

Please rate the information you have received about each of the following aspects of your medicines by ticking the appropriate box.

Although the questions only talk about one medicine, if you have to take more than one please give your overall feeling about information you have received about all of your medicines.

12. [redacted]	AMOUNT OF INFORMATION RECEIVED:				
	Too Much	About right	Too Little	None received	None needed
[redacted]					

Question taken from: Satisfaction with Information about Medicines Scale (SIMS) © Rob Horne 1995 Horne, R., Hankins, M., & Jenkins, R. (2001). The Satisfaction with Information about Medicines Scale (SIMS): A new measurement tool for audit and research. *Quality in Health Care, 10,* 135-140.

QUESTIONS ABOUT USING YOUR MEDICINES

- **Many people find a way of using their medicines which suits them.**
- **This may differ from the instructions on the label or from what their doctor or pharmacist has said.**
- **We would like to ask you a few questions about how you use your medicines.**
- **The information you provide in this questionnaire is anonymous and will not be shared with your pharmacist or doctor.**

Here are some ways in which people have said that they use their medicines.

For each of the statements, please tick the box which best applies to you.

	Always	Often	Some-times	Rarely	Never
13. [redacted]					

Question taken from: MARS_5 RH2_06.doc Medication Adherence Report Scale (MARS_5) ©Robert Horne 1991, 2006)

Comments

Please use this space if you wish to make any comments about the way you have answered Q13.

- **We would also like to ask you about your personal views about medicines in general.**

These are statements other people have made about medicines in general.

Please indicate the extent to which you agree or disagree with them by ticking the appropriate box.

14. [redacted]	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
[redacted]					

Question taken from: Horne, R., Weinman, J., & Hankins, M. 1999, "The Beliefs about Medicines Questionnaire: The development and evaluation of a new method for assessing the cognitive representation of medication", *Psychology and Health*, vol. 14, pp. 1-24

BACKGROUND INFORMATION

- **Finally, we'd like to ask some questions about you.**

15. Gender: Male ☐ Female ☐

16. Age: _____ years

17. How would you describe your ethnic origin? *(Please tick **ONE** box only).*

White:	☐ English/Welsh/Scottish/ Northern Irish/British	☐ Irish	☐ Gypsy or Irish Traveller	☐ Other
Asian or Asian British:	☐ Indian	☐ Pakistani	☐ Bangladeshi	☐ Other
Black or Black British:	☐ Caribbean	☐ African	☐ Black Other	
Mixed / multiple ethnic groups:	☐ Black Caribbean/White	☐ Black African/White	☐ Asian/White	☐ Other
Chinese/ other ethnic group:	☐ Chinese	☐ Arab	☐ Other	

18. Have you been diagnosed with any of the following long-term medical conditions?
*(Please tick **ALL** those that apply, **including those that you do not currently take medicine for**)*

☐ High blood pressure or high cholesterol	☐ Angina or other long-term heart problem	☐ Asthma or other long-term breathing problem	☐ Diabetes
☐ Long-term thyroid problem	☐ Kidney or liver disease	☐ Long-term stomach or bowel problem	☐ Arthritis or other long-term joint problem
☐ Long-term back or other musculoskeletal problem	☐ Anxiety/depression or other long-term mental health problem	☐ Epilepsy or other long-term neurological problem	☐ Previous stroke or Transient Ischaemic Attack (TIA)
☐ Alzheimer's disease or dementia	☐ Cancer	☐ Long-term skin problem	☐ Long-term eye problem
☐ Alcohol or other substance misuse	☐ Other *If other, please write in:*		

THANK YOU FOR COMPLETING THE QUESTIONNAIRE. PLEASE RETURN TO:

Dr Sally Jacobs

FREEPOST [redacted], THE UNIVERSITY OF MANCHESTER, MANCHESTER PHARMACY SCHOOL, STOPFORD BUILDING, 1ST FLOOR, OXFORD ROAD, MANCHESTER M13 9PT