

**Results Workshop III:  
Usability and validity of a classification**

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# Participants

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# Introduction

Many assessors (researchers and/or pharmacists) do not find the classification easy to use. Can this be mended? Is some sort of training desirable/necessary, and under what circumstances? Can the classification be applicable for both community and hospital? Can it be used for documenting problems in retrospective medication review? What needs to be adapted for optimal usability?

# Desired outcome

*Guidelines and suggestions for the use  
of a classification with valid results*

# Validity of a DRP classification

- To improve validity you don't need a study; however, to assess it you need a study
- A DRP classification should be possible to use in both hospital and community pharmacy => same classification appropriate but both a higher detection rate and a better quality likely in the hospital, due to the availability of clinical patient data and closer collaboration with medical doctors

*Workshop discussion based on Modified document on validation of patient assessed health instruments, for use with a drug-related problems classification (Symposium binder, p.45)*

- Appropriateness: face validity
- Acceptability: instrument acceptable to users?
- Feasibility: instrument easy to administer?
- Interpretability: of scores of instrument
- Precision: content validity
- Reliability: equal results by different assessors?
- Responsiveness: follow up of interventions and outcomes of interventions

*N.B. Workshop participants found overlap between the different criteria!*

# Basics

- An assessment of the definition of the DRP is needed. Every pharmacist providing patient care should be able to identify DRPs and categorise them. Clinical knowledge facilitates identification and categorisation.
- To improve validity, assure appropriateness and precision

# Appropriateness (=face validity)

To test and to improve the validity:

- have a number of pharmacists observed on how they categorise DRPs in a set of patient cases (overlap or missing DRP classification categories...)
- focus groups to get different opinions and apply the Delphi method to reach a consensus on data for classification



# Reliability

- Reproducibility: test-retest DRP classification concordance of patient cases among same assessors on repeated measurements
- Inter-rater reliability: DRP classification concordance of patient cases among different assessors

# Prevalence validity

Increase DRP documentation rate to approach true prevalence by means such as:

- focus on selected patient groups/diseases/drugs during a limited data collection period
- practice of counselling models, containing key questions to patients
- use of electronic prompts/reminders in dispensing software

# Usability

- Acceptability
- Feasibility
- Interpretability

# Acceptability

Decide whether to use a DRP classification with several categories for more detailed data or a classification with few categories or an hierarchical system with main categories and sub categories:

- keep it simple to increase documentation rate and decrease misclassification and coding time
- improve acceptability and validity to get it implemented in daily practice (user friendly)

# Feasibility

IT based system the number one choice,  
preferably included in the regular dispensing  
software;

if not possible, in a separate programme

The programme should be able to generate  
statistics

# Interpretability

The DRP classification instrument should be supported by a manual with definitions explanations and examples on DRP classification