

Customer feedback questionnaire:

Evaluation of the OTC Codeine Referral Pilot

Thank you for participating in the Over the Counter (OTC) Codeine Referral pilot in your Community Pharmacy. By “**OTC Codeine**” we mean pain relief medicines containing codeine e.g. co-codamol, Solpadeine®, Nurofen Plus®, Paramol®, etc.

We are evaluating the OTC Codeine Referral pilot and would appreciate feedback on your experience today. **Completing this form is voluntary** and should only take a few minutes. Your feedback is important to us and will help inform decisions about the pilot.

Your responses are anonymous, i.e. you are not required to give any personal details and cannot be identified or contacted after completing this form. Pharmacy staff will not see the form.

Once you have completed the questionnaire, please fold over this form, place it in the attached envelop and seal it. Please hand this envelop back to pharmacy staff who will forward this to PHA Health Intelligence

MANY THANKS FOR YOUR HELP

1. How would you describe your interactions today with pharmacy staff about your use of OTC codeine?

- Very helpful Helpful Neutral Unhelpful Unwanted

2. Do you feel the information you received about your use of OTC codeine was relevant and useful?

- Yes, very much so Yes, partly No

3. Has your awareness about the risks of using OTC codeine changed as a result of your interactions with pharmacy staff today?

- Yes, it has increased No, it has stayed the same I'm not sure

4. How acceptable was each of the following for you? Please tick one box for each row.

	Acceptable	Unsure	Not acceptable	Does not apply
Being approached by pharmacy staff about your use of OTC codeine products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completing some questions about your use of OTC codeine products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receiving advice about OTC codeine and how to reduce your usage and manage your pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being offered a referral to the local Community Addiction Service if you are at higher risk or highest risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recording your personal details (e.g. name, gender) on a referral form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Where did pharmacy staff talk to you about your use of OTC codeine products? Please tick one option only.

- Quiet area near the counter
 In consultation room
 In both

 Other, please say: _____

6. How did you feel about the level of privacy given when talking about your use of OTC codeine products? Please tick one option only.

- Comfortable
 Not comfortable ▼
 Unsure

Please say why:

7. How would you rate the pharmacy staff that talked to you about your use of OTC codeine products? Please tick one box for each row.

	A lot	A little	Not
Staff were friendly and made me feel comfortable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff were well informed and knowledgeable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff were respectful and did not judge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff were well informed about available support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. After speaking with the pharmacist today, are you likely to think twice about using OTC codeine?

- Yes, definitely
 Yes, somewhat
 No
 I'm not sure

9. After talking about your use of OTC codeine products with pharmacy staff, which of the following describes you best? Please tick one option only.

- I'm planning to cut down on my own.
 I'm **not** planning to cut down.

 I'm planning to cut down but need help to do so.
 I don't know.

 I think I should cut down, but I'm not ready yet.

10. Are you ...? Please provide your gender and age group (in years).

- Gender:** Male
 Female
 Other
 Prefer not to say

Age: 18-24
 25-34
 35-49
 50-64
 65 or older