Ensuring Patient Safety in Older Adult Prescribing

Priti Patel: Integrated Care Pharmacist- Guy`s and St. Thomas` NHS Foundation Trust

Slides adapted from Lelly Oboh, Consultant Pharmacist in Older People

Learning Outcomes

- ❑Issues faced when prescribing
- ❑Prescribing in older people and considerations
- ❑Case studies
- ❑How to manage polypharmacy
- ❑Considerations for deprescribing
- ❑Tools and strategies to manage polypharmacy
- ❑Questions

First steps

- ❑ What medicines is your patient already prescribed?
- ❑ OTC
- ❑ Hospital prescribed medicines

Medicines reconciliation[1]:

- ❑ Supports your prescribing decisions and the most appropriate medicines to prescribe
- ❑ 3 sources
- ❑ Access to records across the NHS

1.NICE, 2015, Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guideline [NG5]

Structured medication review

Classification: Official

Publishing approval reference: PAR0127

Network Contract Directed Enhanced Service

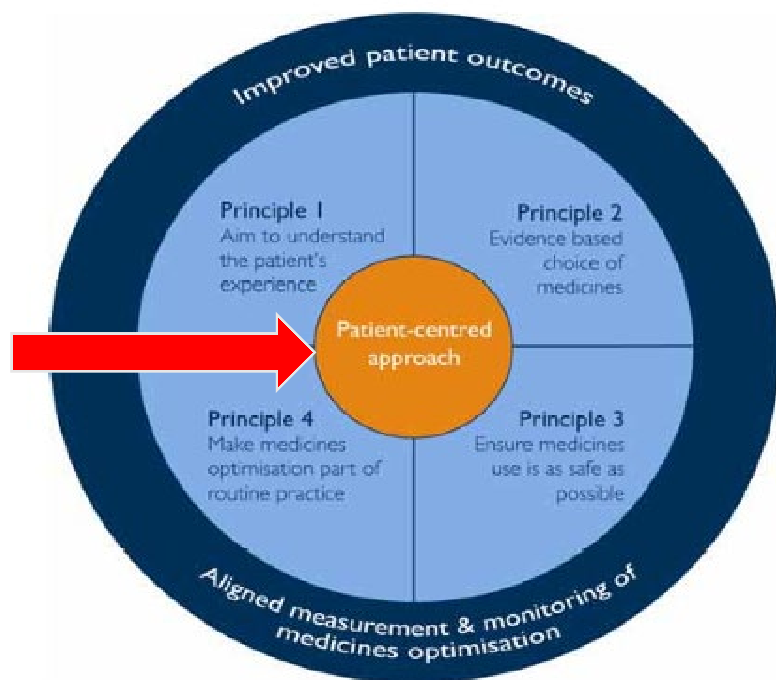
Structured medication reviews and medicines optimisation: guidance

GP Practice Pharmacists

Primary care Network (PCN) Pharmacists

Medicines Optimisation

Outcome focused approach to **safe** and **effective** use of medicines that takes into account the **patient's values, perception** and **experience** of taking their medicines



- **Important Outcomes for adults[4]**
- - Improved quality of life
- - Making a positive contribution
- - Improved health and emotional wellbeing
- - Personal Dignity
- - Control and choice
- - Economic wellbeing
- - Freedom from discrimination

- *Independence Well-being and Choice 2005, Our health, our care, our say 2006, Strong and Prosperous Communities 2006*

http://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

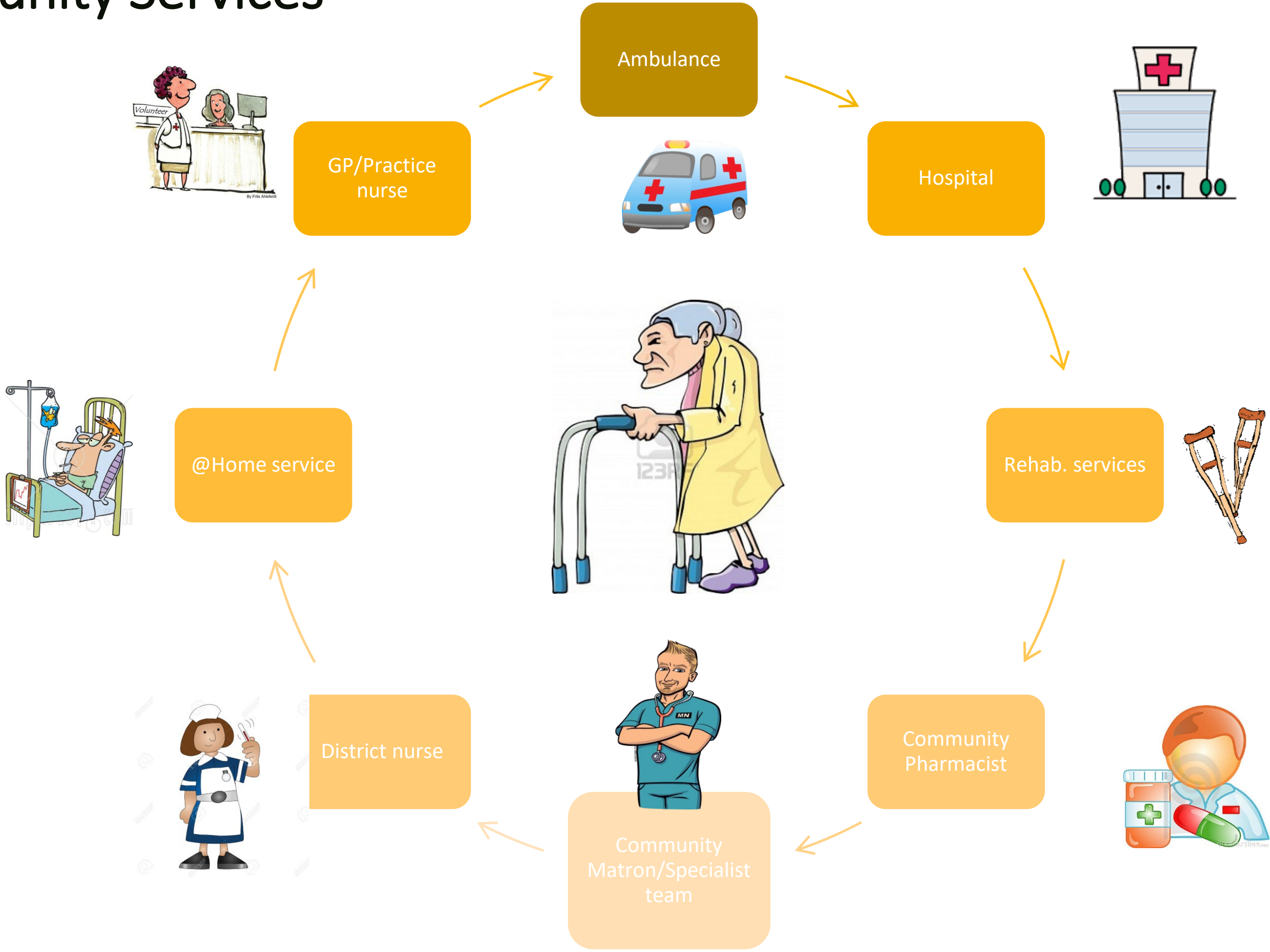
British National Formulary (BNF)

Medicines guidance

Guidance on prescribing	Prescription writing	Emergency supply of medicines
Controlled drugs and drug dependence	Adverse reactions to drugs	Guidance on intravenous infusions
Medicines optimisation	Antimicrobial stewardship	Prescribing in children
Prescribing in hepatic impairment	Prescribing in renal impairment	Prescribing in pregnancy
Prescribing in breast-feeding	Prescribing in palliative care	Prescribing in the elderly
Prescribing in dental practice	Drugs and sport	Index of manufacturers
Special-order manufacturers	Life support algorithm (image)	Non-medical prescribing

https://bnf.nice.org.uk/guidance/

Community Services



Case study 1- example

- 85 year old male patient
- Nil POC
- Lives alone
- Degree of cognitive impairment
- MOCA 15/30
- PMH-CABG/MI, previous vasculitis, renal impairment, HFrEF, COPD

Main concerns?

Medications

- Dosette boxes – TDS
- Co-trimoxazole 480mg OM
- Bisoprolol 10mg OM
- Aspirin disp. 75mg OM
- Furosemide 40mg OM
- Sodium bicarbonate 500mg TDS
- Atorvastatin 80mg ON
- Inhalers/Nebs. –tiotropium respimat, salbutamol inhaler and fostair nexthaler, salbutamol 5mg nebuliser PRN

What to do?

What`s important to the patient?

- Not his medications
- Experiencing SOB all day- in the context of COPD and HF

Main issue:

- Medications ‘make no difference to me, I have no pain’
- Following an agreed plan and confirming the patient`s understanding of his medications in relation to his multi-morbidities
- Reduced pill burden
- Hard of hearing-cannot hear over the telephone

Patient Outcome

- Stopped sodium bicarbonate and co-trimoxazole- started 2018 for PCP prophylaxis post IV cyclophosphamide treatment for vasculitis
- Reduced atorvastatin from 80mg ON to 20mg OM, last TC 4.3mmol/L
- All medications changed to morning only in dosette box
- Community pharmacy to deliver new dosette boxes

•Positive effects:

- Reduced polypharmacy
- Patient more likely to adhere as only morning medications and fewer of them
- Patient more accepting of taking fewer medicines

Case study 2- example

- 86 years, female, AD, main carer: daughter
- Main issue: restless/night time waking due to dementia

MEDICATION	INDICATION	COMMENTS	ADHERENT?	OUTCOME
FERROUS FUMARATE 210MG	Low Hb 102 Nov. 2019	Caused constipation, refused to take	No	Daughter has stopped
MEMANTINE 10MG ON AND DONEPEZIL 10MG ON	Dementia	Caused nausea and diarrhoea, refused to take	No	As above
ATORVASTATIN 20MG ON	Last TC 5.6 Nov. 2019, weight 43kg Feb. 2020	Refuses	No	As above
FOLIC ACID 5MG OD	Last folate 2.3 Nov. 2019	Refuses	No	As above
PROMETHAZINE 10MG BD	Restless at night	Daughter places in decaff. coffee	Yes	Stopped by CMHT

Case study 2- Actions?

Things to consider?

- Daughter crushing promethazine and placing in decaff. coffee
- covert administration
- patient does not have capacity
- only drinks decaffeinated coffee

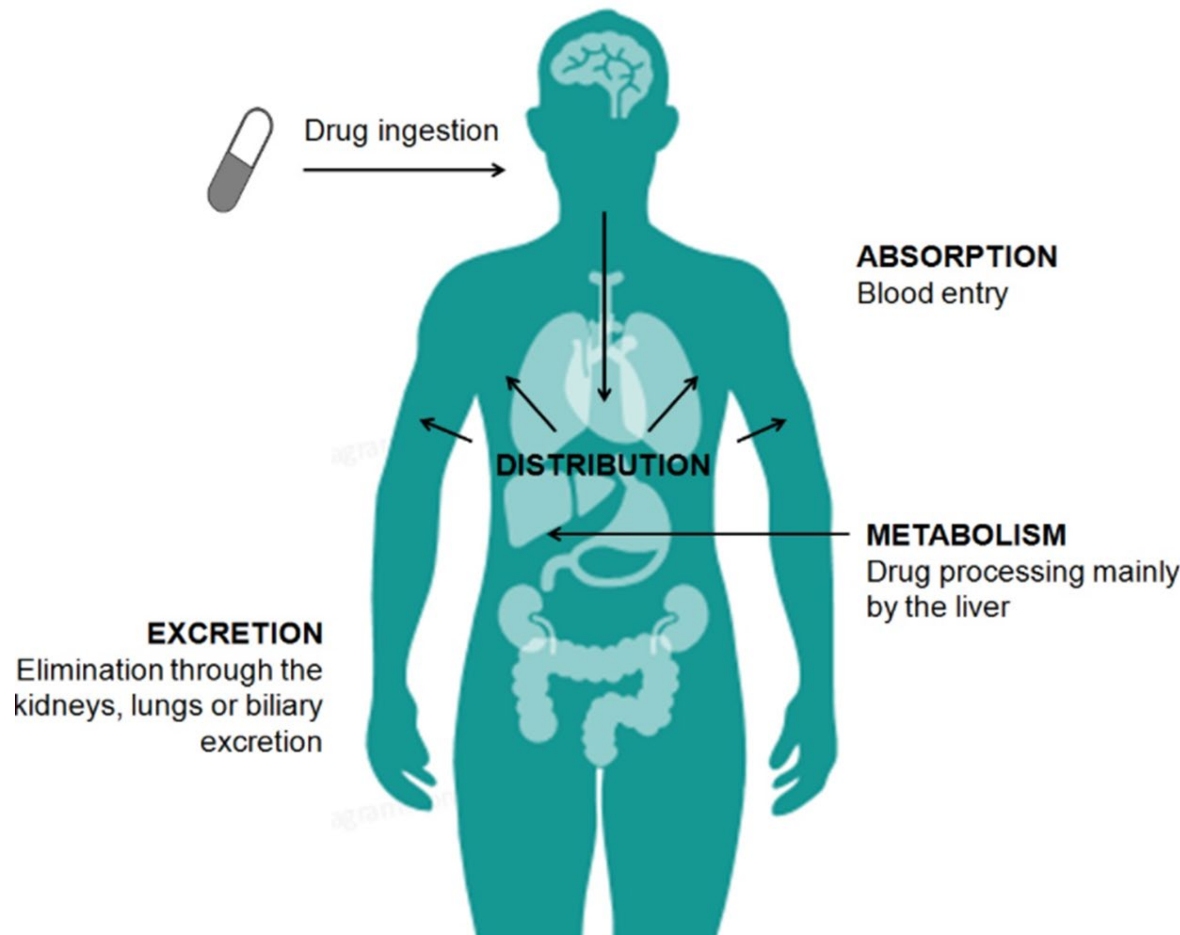
Solutions:

1. community mental health team (CMHT) referral
2. clinical review by CMHT
3. best interest meeting: daughter, CMHT, Pharmacist, GP

Case study 2- Outcome

- CMHT review
- trialled trazadone 50mg ON- ineffective
- best interests meeting decision made to trial melatonin MR 2mg evening- crushed and added to tepid decaff. coffee
- next commenced on mirtazapine 7.5mg ON orodispersible in decaff. coffee
- no simple solutions
- Main focus for patient and daughter- improved sleep, less night time waking

Pharmacokinetics: How does the body handle the drug?



Think about your patient factors:

-age
-weight
-GI surgery
-renal impairment
-liver impairment

Pharmacodynamics: How the drug affects the body

- Increased sensitivity to CNS medications-falls, drowsiness, confusion
- Anticholinergic effects (AEC)
- Diuretic effects-increased urinary frequency, electrolyte imbalances, hypotension/postural
- Opioid effects- constipation, resp. depression, dependence (MHRA, 2020, opioids: risk of dependence and addiction)

Consider potential negative effects the medication will have on your patient

National overprescribing review 2021

-WHO defines as four or more medicines

-Academia five or more

-NHS Scotland uses 10

-GP practice data based on NHS BSA polypharmacy definitions: 8

-Overprescribing review defines as polypharmacy at both 5+ and 8+

Department of Health & Social Care

Good for you, good for us, good for everybody

A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions

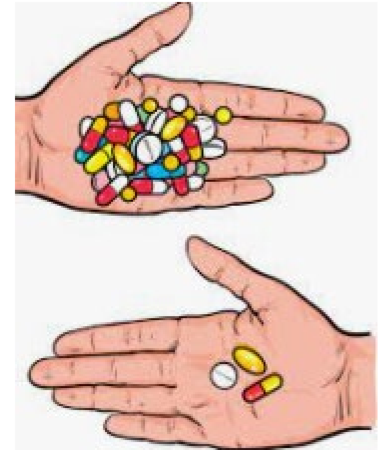
Published 22 September 2021

Adverse drug effects

- Approx. 6.5% hospital admissions
- Over 65 years up to 20% due to adverse effects
- Over 200 requests for repeat items a day- 2 hrs to review and prescribe[2]

2. Dept. of Health and Social Care, 2021, Good for you, good for us, good for everybody. A plan to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions.

Polypharmacy



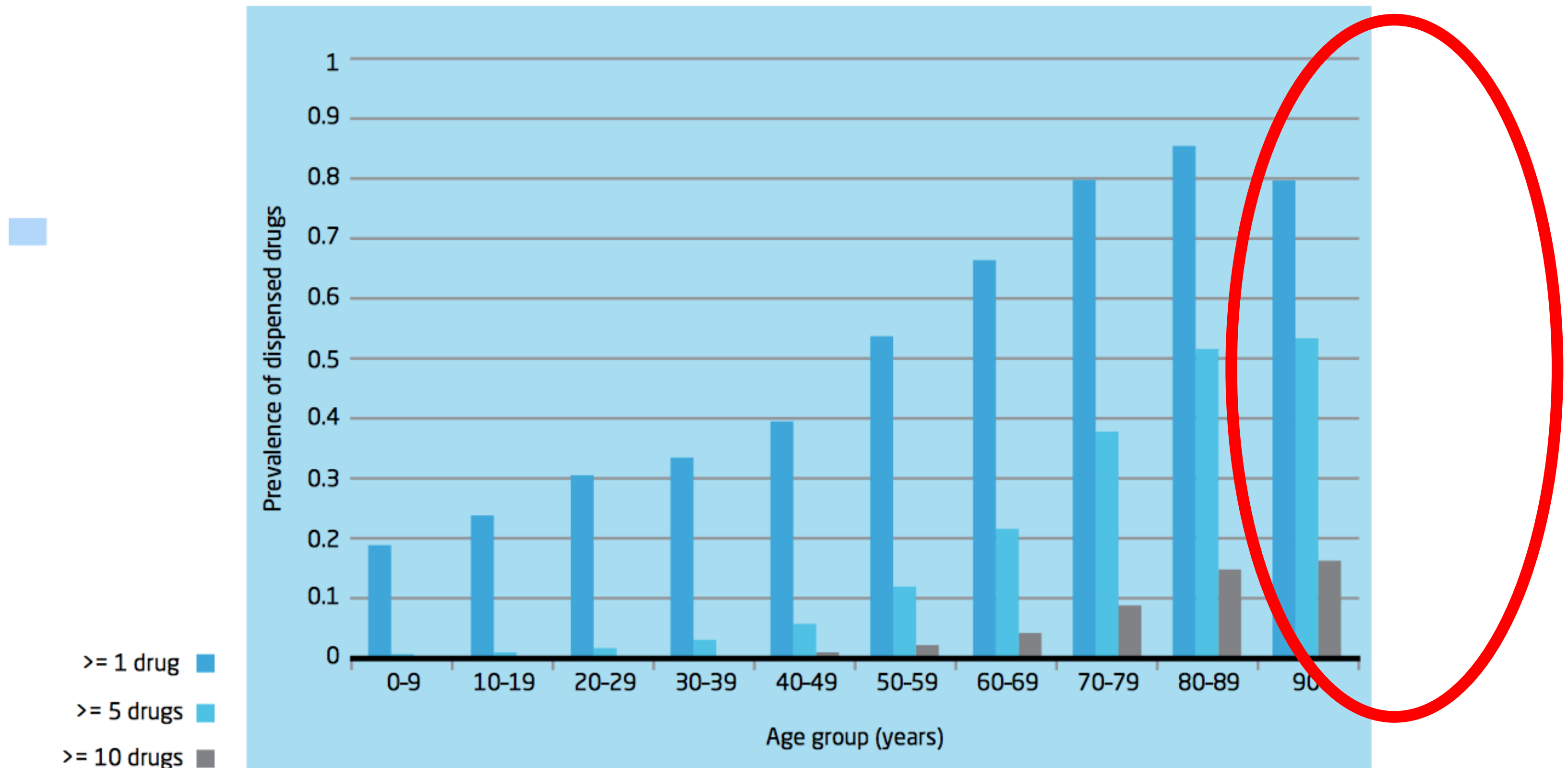
- Use of more than 4/5 drugs at the same time
- Use of more drugs than is clinically indicated
- More common with, but not limited to older people
- Can be appropriate

Royal Pharmaceutical Society [1]:

1. Medication no longer clinically indicated
2. Benefit not outweighing the harm
3. Multiple medicines causing harm
4. Practically no longer manageable/causing harm/distress

1.RPS polypharmacy: getting our medicines right: https://www.rpharms.com/recognition/setting-professional-standards/polypharmacy-getting-our-medicines-right#background

Number of meds. vs. age



Source: Hovstadius *et al*, (2010b)

Reasons for Polypharmacy?

Multiple morbidities

Increased longevity

Advancements in drug therapy and preventative strategies

⇑ Accessibility to medicines e.g. non prescription drugs

NHS guidance and targets e.g. QOF, NICE quality standards

Reluctance to discontinue drugs

Mistaking ageing for disease/inappropriate response to non-medical problems

Polypharmacy drivers

Increase Prescribing ⇄ **Hinder Deprescribing**

Increase Prescribing:

- Multiple long term conditions
- Increasing age
- Therapeutic advancements and new drugs
- Increased accessibility to medicines
- NHS guidance and targets ⇨QOF, NICE quality standards
- Multiple prescribers
- A "pill for every ill" and psychosocial issues
- Poor therapeutic goal setting
- Patient or carer demand
- Prescribing cascade

Hinder Deprescribing:

- Fear of litigation
- Poor evidence for stopping therapy
- Non-adherence ⇨ "therapeutic failures"
- Poor communication and Transfer of information
- Poor medication review
- Treating condition vs. patient
- Non-pharmacological options not readily available or accessed

Deprescribing

The **<u>continuous</u> process** of identifying and discontinuing drugs in which *potential* or actual harm outweighs *potential* or actual benefit…..when considered in the context of a patients **individual care goals**.

E.g. the patient's physical functioning, co-morbidities, preferences and lifestyle.

"Experience suggests that both prescribing and deprescribing would lead to **similar claims of litigation** and the same legal tests will apply"

(N.Barnett and O.Kelly Legal implications of deprescribing)

"A patient is entitled to considered medical advice, application of evidence, full disclosure of all material risks and be informed of any reasonable alternative. This applies **<u>equally</u>** whether the decision is being made to start, stop or continue a medication"

(N.Barnett and O.Kelly Legal implications of deprescribing)

Deprescribing:
Identify inappropriate drugs from an accurate list of medicines

- Clinical judgments and experience

- Does each drug have a matching indication, is the indication still valid
- Does the drug produce limited benefit for that indication
- Is it a high risk drug
- Are the benefits outweighed by unfavorable ADRs

MEDICHEC

ASSESSMENT

1

One by one, type the names of the nedications your patient is currently taking into the search bar

2

Click on the '+' symbol to add a medication to your list

3

Refer to the results below to see your entered medications

Search medication ..

Please note Medichec relies on a UK database of generic (unbranded) medication names. If a drug is not identified in a search please try the English/US spelling. If in doubt please check with a local physician or pharmacist to clarify drug names.

Add custom drug

Anticholinergic effect (AEC) tool- available as an app.

South London and Maudsley NHS
NHS Foundation Trust

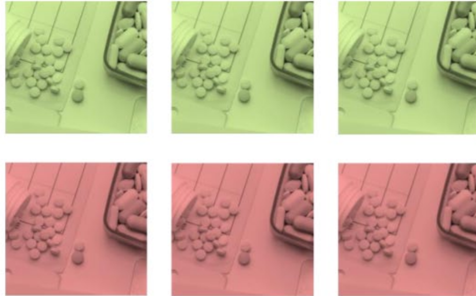
Different targets based on different needs and life expectancy – what are we trying to achieve?

- Little to no evidence for elderly patient treatments
- Multimorbidity
- NICE – BP target in over 80's 150/90
- International diabetes federation (IDF) - HbA1c can be relaxed
- Consider pill burden of treatment (risk vs benefit)
- IDF Global Guideline for Managing Older People with Type 2 Diabetes

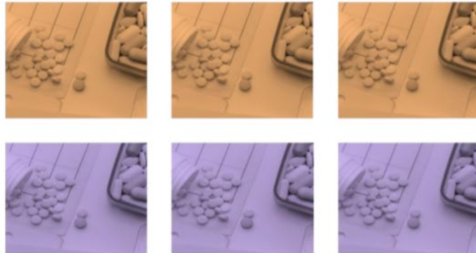
	HbA1c
Functionally Independent	7.0%- 7.5% (53-59mmol/mol)
Functionally dependant	7.0% - 8% (53-64mmol/mol)
Frail/Dementia	Up to 8.5% (70mmol/mol)
EOL	Simply avoid symptomatic hyperglycaemia

International Diabetes Federation guideline – global guideline for managing older people with type 2 diabetes 2013.

NHS Scotland Polypharmacy Resources



Polypharmacy Guidance
Realistic Prescribing
3rd Edition, 2018



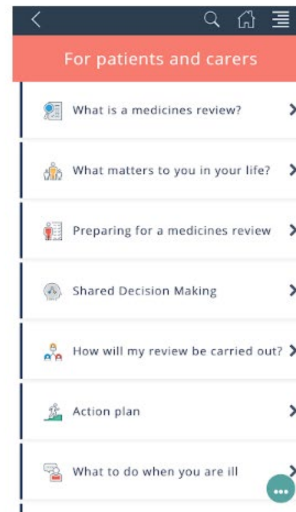
REALISTIC MEDICINE
Scottish Government
Riaghaltas na h-Alba
gov.scot
NHS

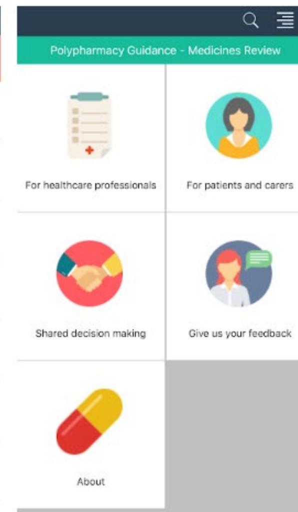
Managing Multiple Medicines

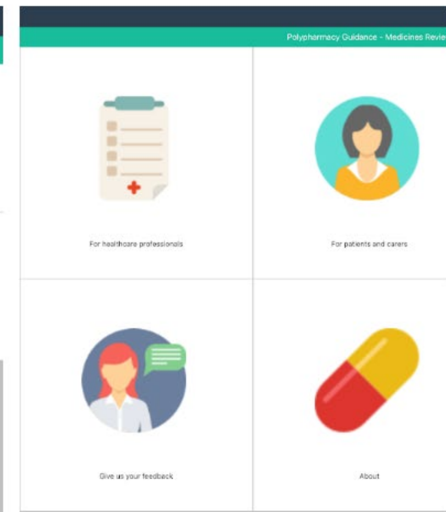
NHS Education for Scotland Medical

PEGI 3

Install







RPS- Polypharmacy getting our medicines right

Polypharmacy: Getting our medicines right

Sections on this page

- Key Messages
- Best practice
- Audience, Definitions, Purpose and Scope
- Background
- Polypharmacy and People
- Polypharmacy and Healthcare Systems
- Polypharmacy and Healthcare Professionals
- The Future for Polypharmacy
- Appendices

- Multiple long term conditions- creates a ‘pill for every ill’

- Very old age
- Dementia
- Co-morbidity
- Frailty
- Limited life Expectancy

Tools to identify Potentially inappropriate medicines (PIMs) in older people

Age and Ageing Advance Access published October 16, 2014

Age and Ageing 2014; **0:** 1–6
doi: 10.1093/ageing/afu145

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STOPP/START criteria for potentially inappropriate prescribing in older people: version 2

Denis O'Mahony[1,2], David O'Sullivan[3], Stephen Byrne[3], Marie Noelle O'Connor[2], Cristin Ryan[4], Paul Gallagher[2]

[1]Geriatric Medicine, University College Cork, Cork, Munster, Ireland
[2]Geriatric Medicine, Cork University Hospital, Cork, Munster, Ireland
[3]School of Pharmacy, University College Cork, Cork, Munster, Ireland
[4]School of Pharmacy, Queen's University, Belfast, Northern Ireland, UK

Address correspondence to: D. O'Mahony. Tel: (+353) 214922396; Fax: (+353) 214922829. Email: denis.omahony@ucc.ie

Abstract

Purpose: screening tool of older people's prescriptions (STOPP) and screening tool to alert to right treatment (START) criteria were first published in 2008. Due to an expanding therapeutics evidence base, updating of the criteria was required.
Methods: we reviewed the 2008 STOPP/START criteria to add new evidence-based criteria and remove any obsolete criteria. A thorough literature review was performed to reassess the evidence base of the 2008 criteria and the proposed new criteria. Nineteen experts from 13 European countries reviewed a new draft of STOPP & START criteria including proposed new criteria. These experts were also asked to propose additional criteria they considered important to include in the revised STOPP & START criteria and to highlight any criteria from the 2008 list they considered less important or lacking an evidence base. The revised list of criteria was then validated using the Delphi consensus methodology.
Results: the expert panel agreed a final list of 114 criteria after two Delphi validation rounds, i.e. 80 STOPP criteria and 34 START criteria. This represents an overall 31% increase in STOPP/START criteria compared with version 1. Several new STOPP categories were created in version 2, namely antiplatelet/anticoagulant drugs, drugs affecting, or affected by, renal function and drugs that increase anticholinergic burden; new START categories include urogenital system drugs, analgesics and vaccines.
Conclusion: STOPP/START version 2 criteria have been expanded and updated for the purpose of minimizing inappropriate prescribing in older people. These criteria are based on an up-to-date literature review and consensus validation among a European panel of experts.

Keywords: *inappropriate prescribing, older people, STOPP/START criteria*

- STOPP/START criteria (O'Mahoney 2014)
- STOPPFrail 2017

Others

- CRIME (Age and Ageing 2014)
- Beers Criteria (Updated 2015)

http://ageing.oxfordjournals.org/content/early/2014/10/16/ageing.afu145.full.pdf+html

When to deprescribe?

- At every opportunity, but especially:

- Presenting with **new symptoms** – could this be medicine related?
- Presenting with **altered physiology**
- Patients with **advanced disease/ terminal illness**
- **Polypharmacy**
- Patients taking medication to prevent future disease where **no additional benefit may be gained from continued use**.

❖ Examples include antihypertensives, PPIs, statins, bisphosphonates

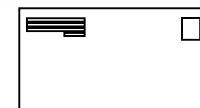
❖ Amitriptyline, pregabalin, gabapentin – neuro. pain, codeine

Tools you need to manage polypharmacy/ deprescribing

- Consultation Skills (patient centred and values based)
- Therapeutic skills
- Research evidence
- Deprescribing tools
- Care co-ordination
- Appreciation of complexity in care of older people and ‘nurturing care’
- Challenging to do, can require multiple reviews/time constraints

Strategies to overcome barriers

- ❑Clear <u>COMMUNICATION</u>
- ❑Clear and precise instructions – ensure you are aware where to check for the answers: BNF, medicines.org.uk, Pharmacy team, acute Trust medicines information teams
- ❑Complete actions don't pass the buck – "GP to start…"
- ❑"GP to review"
- ❑"As Directed" "Affected area"
- ❑Follow up and review
- ❑Is the patient clear on how to take their medicines/indication/duration- will they remember?



Non adherence

Uncontrolled pain
Nausea
Uncontrolled dizziness
Poor diabetes control
Feels full after taking medications
"Just so many – where do I begin with them"

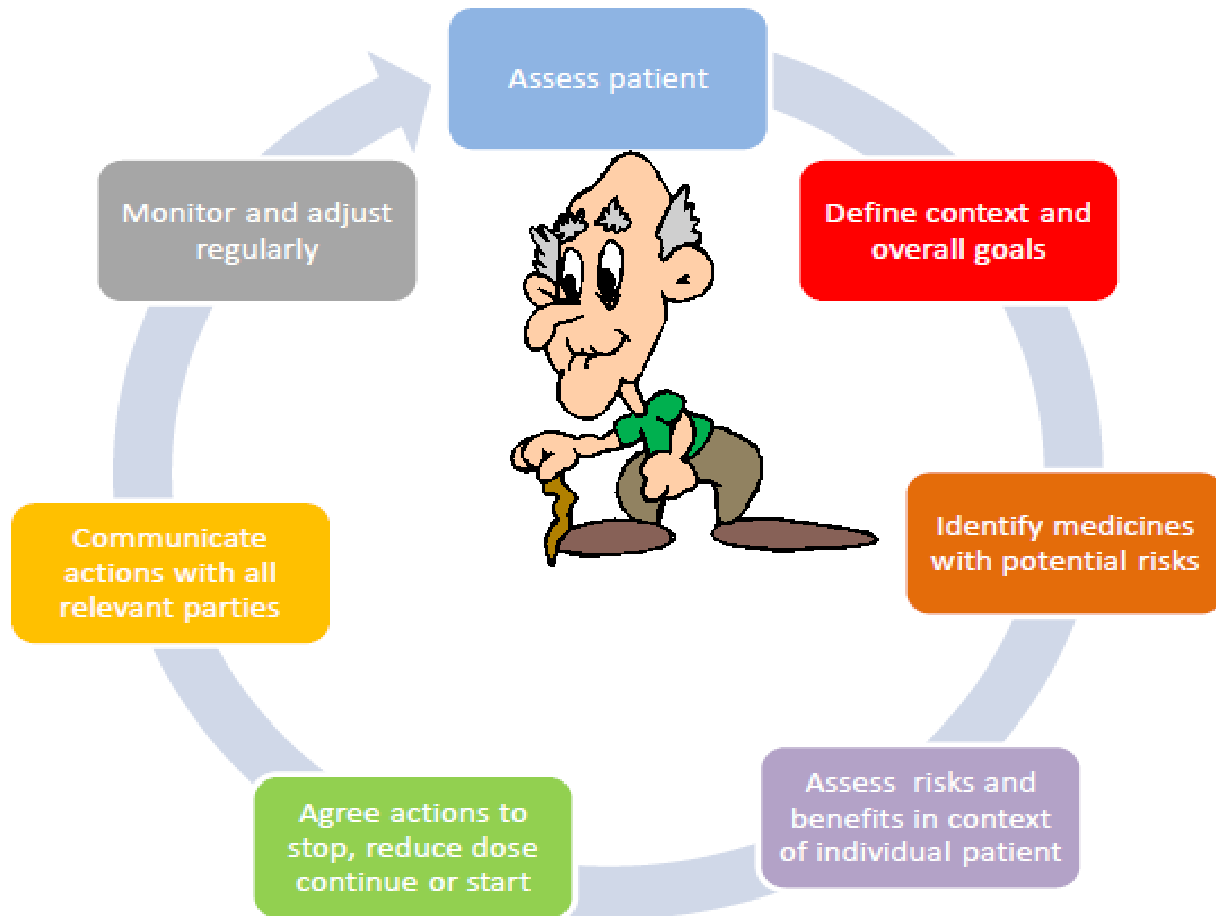
Medicines Waste- £300 million [1]

- Estimated £90 million unused medicines in individuals' homes
- £110 million returned to community pharmacies in a year
- In care homes: £50 million- unused NHS supplied medicines to be disposed of

1. Hazell, B. and Robson, R. 2015. Pharmaceutical waste reduction in the NHS. NHS BSA

Patient engagement is key!

What happens when we don’t communicate


A patient centred approach to managing polypharmacy in practice
Assess patient
Define context and overall goals
Identify medicines with potential risks
Assess risks and benefits in context of individual patient
Agree actions to stop, reduce dose continue or start
Communicate actions with all relevant parties
Monitor and adjust regularly
N Barnett L Oboh K Smith, NHS Specialist Pharmacy Service, 2015

Summary

- Older people take more drugs than other age groups
- Polypharmacy can be associated with poor clinical outcomes, adverse effects, increased costs and wastage
- Deprescribing is as important as prescribing to optimise medicines use in older people
- **Regular patient-focused** medication review is NEEDED
- Integrated care and multidisciplinary working is vital
- Always consider the long term plan for prescribing- opioid patches
- General issues faced: reading labels on boxes, popping the medicines from the blister, swallowing, strengths of medicines available
- Empower the patient/family/carer

Also remember:

Thank You
Any Questions/Reflections?

contact: p.patel6@nhs.net

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