Greenwich Protected Learning Time

SMR Case scenario

Tackling overprescribing and deprescribing in frailty

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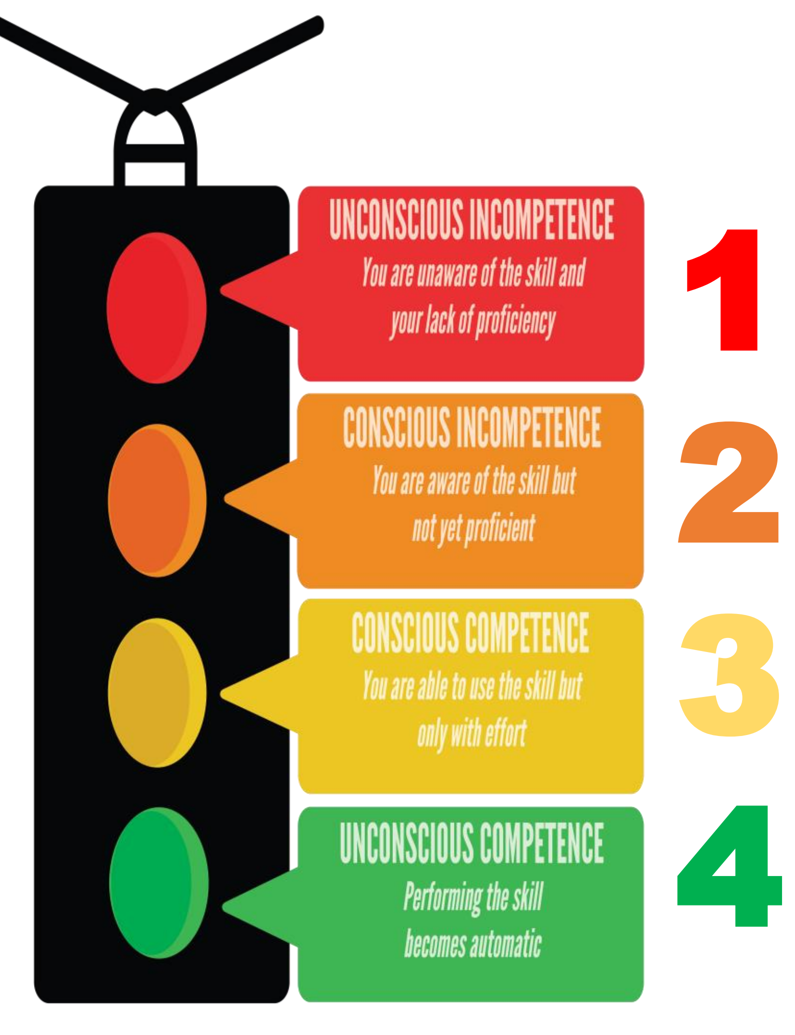
Hello and Welcome

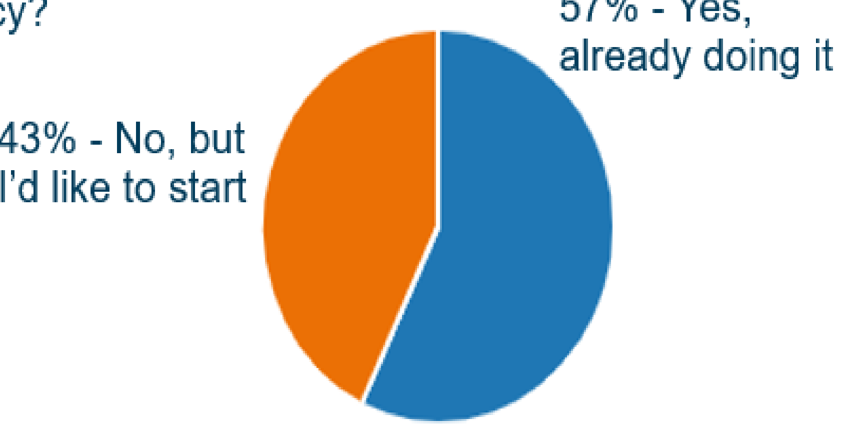
Please rate yourself on how competent are you NOW in the area of (De)Prescribing in older people with frailty multimorbidity and polypharmacy



Hierarchy of competence, Noel Burch 1970

GIPN network survey on reducing inappropriate polypharmacy 2024

1. As a practice pharmacist/community pharmacist, are you currently involved in any work that helps to reduce inappropriate polypharmacy?



2. What are the obstacles?

   Patient declined
   Confidence in stopping meds
   Time and workforce
   Lack of engagement from GP and patients, unclear monitoring responsibilities, "not causing harm to patient, why change?

3. What support would you like?

Paper/electronic resources (one pager)

Clinical support session with 2 case studies

Others

Deprescribing top tips per clinical areas

Many drugs are often continued beyond the point at which they are beneficial and may actually cause harm. *DTB 52:2014*

STRUCTURED MEDICATION REVIEW (SMR) PROCESS

Identify 4Ps 2Cs and Document

1. Identify and Prioritise patient for review

2. Prepare for the consultation

3. Patient-centered Consultation with shared decision making

4. Agree a Plan

5. Co-ordinate care and Collaborate

6. Document

SMR - 1239511000000100

SDM – 815691000000107

Basic information

- ☐ Reason for referral/risk or problem identified
- ☐ Frailty score
- ☐ Relevant MHx – LTCs, acute/major, COVID status/ isolation
- ☐ Relevant previous consultations
- ☐ Recent hospital admission
- ☐ Latest investigations and test results
- ☐ Additional useful info e.g. social care package, learning disabilities, dementia, dexterity, housebound, safety issues
- ☐ Patient's capacity to be involved with decision making or Person with power of attorney (POA)
- ☐ Advance care plan (CMC)
- ☐ Face to face, phone, video consultation

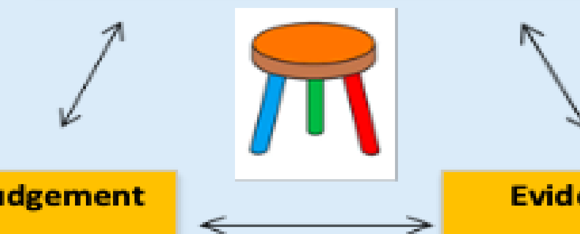
Medicines information

- ☐ Acute medicines
- ☐ Repeat medicines
- ☐ Recently stopped/started
- ☐ Non prescribed medicines and supplements
- ☐ Allergies
- ☐ Multiple compartment aids
- ☐ Potentially inappropriate/high risk drugs

SMR consultation template checklist

1. Identify what matters most to patient at the outset
2. Negotiate shared agenda and goals
3. Take a good history and undertake medicines reconciliation
4. Identify potentially inappropriate medicines (PIMs) and medicines support needs/risks
5. Use & Interpret research evidence in context of individual patient situation and goals
6. Use your clinical judgement to ensure medicines appropriate (safe and effective) in the individual patient's circumstances
7. Check willingness and capability to adhere to medicines
8. Agree and document an action plan for the medicines reviewed (Incl. changes, support, follow up, monitoring, sign posting, referral, safety netting)

Patient circumstances, goals, values and wishes

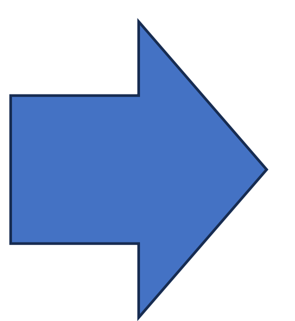


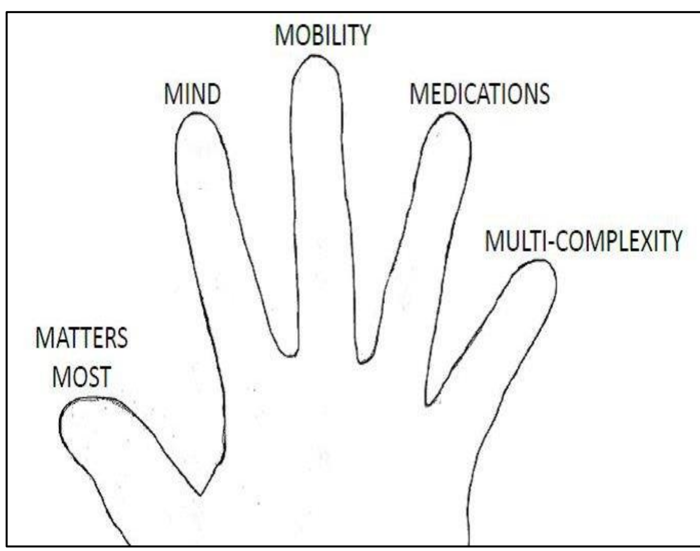
Clinical judgement

Evidence base

Lelly Oboh Mar 2021. Principles for developing SMR tools and templates.
https://future.nhs.uk/PharmacyIntegration/view?objectId=100567717

During your consultation, look through the frailty lens to optimise medicines *(NICE NG56, BGS FFF1, 5M)*





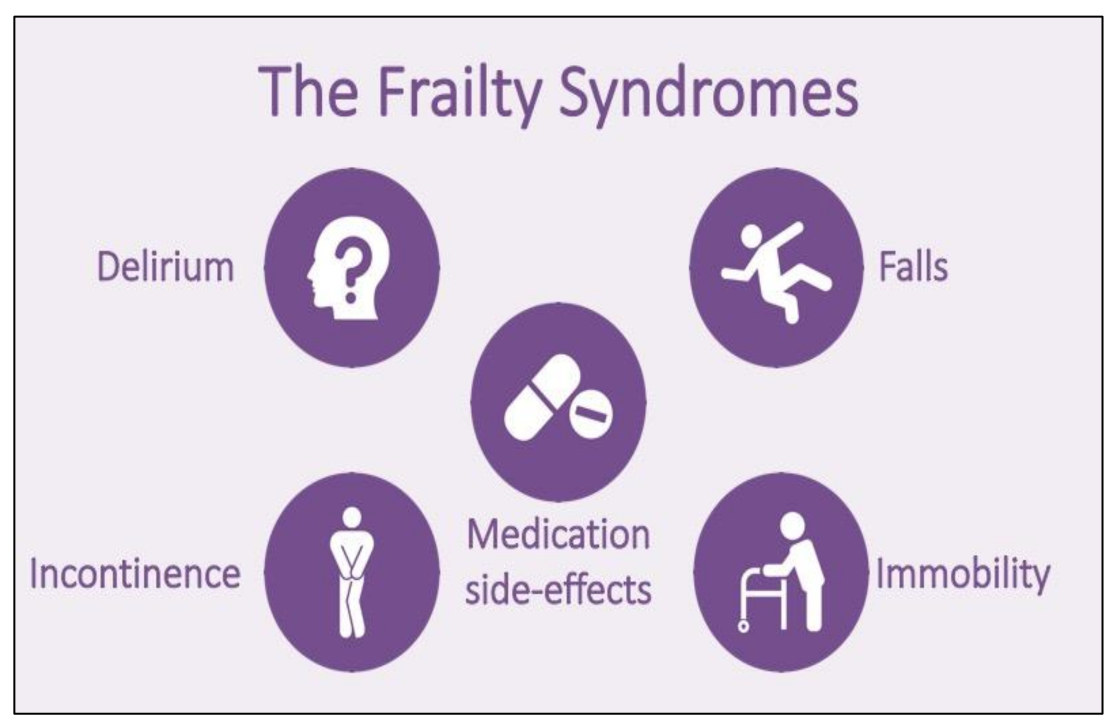
Biomedical

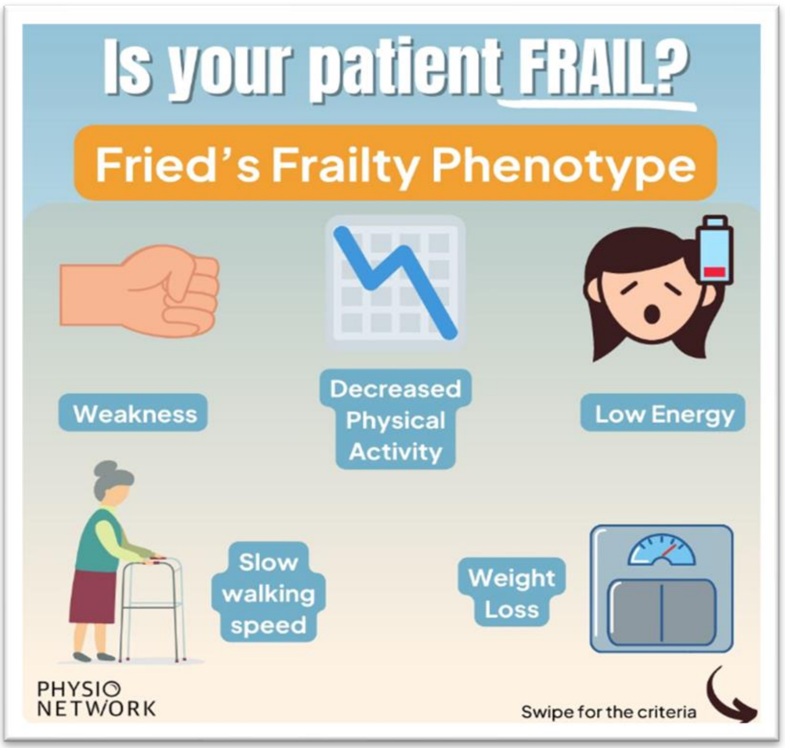
Biopsychosocial

…treat what matters, focus less on prolonging life and more on what makes each patient want to live another day. *Dr Marie Savard 2019*

Prescribing (de-Prescribing) through the frailty lens

Think about the impact of medicines on frailty syndromes and phenotype vs managing individual conditions





"There is a risk of significant harm to patients with frailty if health interventions are planned for them in the absence of recognition of their frailty *(BGS Fit for Frailty 1 & 2 2014 & 2015)*

Case Study 1 discussion

Research Evidence- Tools to identify PIMs

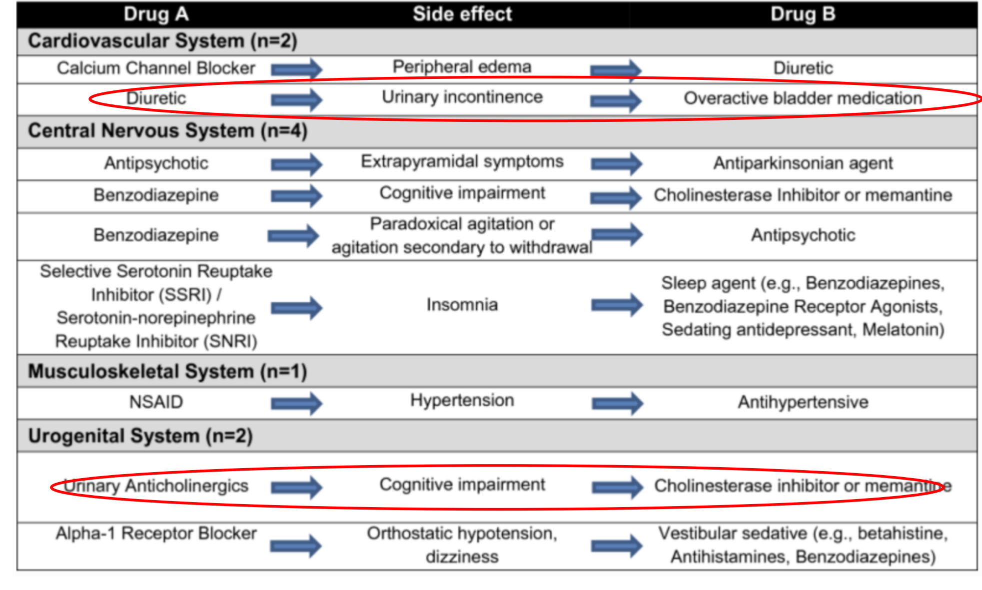
- **STOPFrail 2 2021** Focuses on the Frail older population and identifies medicines-related criteria that highlight potentially inappropriate medicines for people with a limited life expectancy. https://doi.org/10.1093/ageing/afaa159
- **STOPP/START tool v3-** Provides a list of medication which supports prescribers to reduce inappropriate prescribing in older people tool https://www.cgakit.com/_files/ugd/2a1cfa_94280508e6014f3db06594abd0193994.pdf
- **Anticholinergic Burden Scales-**
  - **Medichec** identifies medicines that that potentially negatively affect cognitive function, including those causing dizziness and drowsiness. using the Anticholinergic Effect on Cognition (AEC) scale, which also defines the extent of this effect. http://www.medichec.com/assessment
  - **ABC Calculator** calculates the anti cholinergic burden score and suggests non drug options and alternative drugs with lower burden https://www.acbcalc.com/
- **ThinkCascades tool** For Identifying Clinically Important Prescribing Cascades Affecting Older People https://doi.org/10.1007/s40266-022-00964-9
- **Canadian Deprescribing Network-** Website provides evidence-based guidelines for deprescribing for five areas of medicines including proton pump inhibitors, antihyperglycaemics, antipsychotics, benzodiazepines and anticholinesterases/memantine. https://deprescribing.org/resources/deprescribing-guidelines-algorithms/
- **Medstopper tool (US)-** Online tool where the user can enter a list of medication and provides information about reducing/tapering or stopping medicines and ranks the medicines, rating potential of the medicine to reduce symptoms, risk of future illness and risk of causing harm. http://medstopper.com/

Examples of Tools to identify PIMs for Ms Gordon

Medichec Tool

AEC	QTc Prolongation	Hyponatraemia	Bleeding risk	Dizziness	Drowsiness	Constipation	Drug	AEC Score
		↓Na+					CODEINE	?
		↓Na+					AMITRIPTYLINE	3
		↓Na+					GABAPENTIN	0
		↓Na+					SOLIFENACIN	1

Think cascade Tool



Drug A	Side effect	Drug B
Cardiovascular System (n=2)		
Calcium Channel Blocker	Peripheral edema	Diuretic
Diuretic	Urinary incontinence	Overactive bladder medication
Central Nervous System (n=4)		
Antipsychotic	Extrapyramidal symptoms	Antiparkinsonian agent
Benzodiazepine	Cognitive impairment	Cholinesterase Inhibitor or memantine
Benzodiazepine	Paradoxical agitation or agitation secondary to withdrawal	Antipsychotic
Selective Serotonin Reuptake Inhibitor (SSRI) / Serotonin-norepinephrine Reuptake Inhibitor (SNRI)	Insomnia	Sleep agent (e.g., Benzodiazepines, Benzodiazepine Receptor Agonists, Sedating antidepressant, Melatonin)
Musculoskeletal System (n=1)		
NSAID	Hypertension	Antihypertensive
Urogenital System (n=2)		
Urinary Anticholinergics	Cognitive impairment	Cholinesterase inhibitor or memantine
Alpha-1 Receptor Blocker	Orthostatic hypotension, dizziness	Vestibular sedative (e.g., betahistine, Antihistamines, Benzodiazepines)

STOPP/START tool vs 3- Consider stopping

- B15- TCA causing QT prolongation
- D1 TCA causing constipation, ortho hypotension
- L5- Gabapentin for non-neuropathic pain

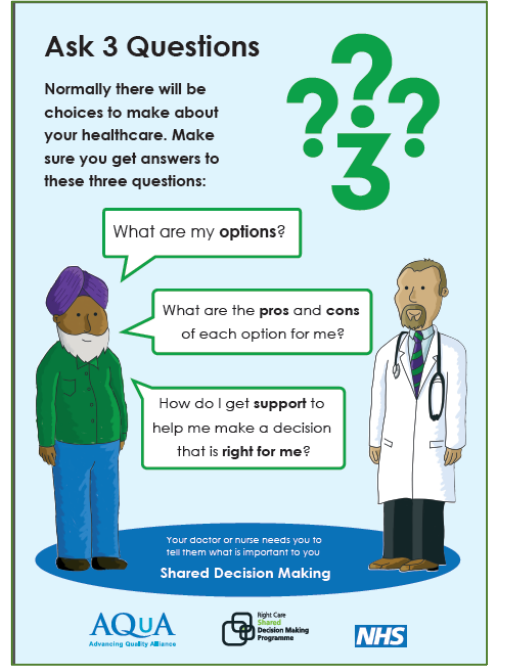
CLINICAL JUDGEMENT AND DECISION MAKING- Tools

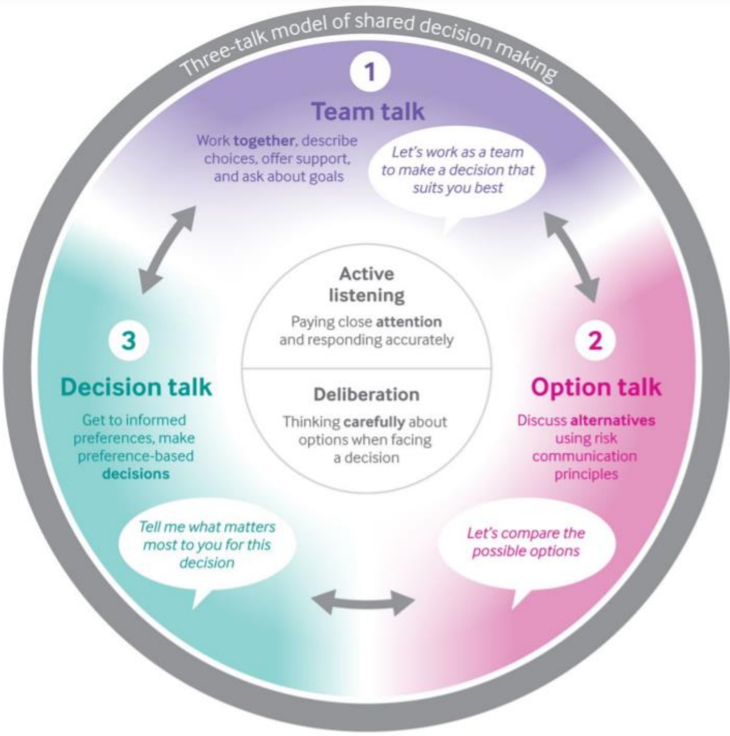
Personalising evidence based medicine

- Conversations to manage uncertainties, explain risks vs benefits and options including non-drug. Sometimes difficult conversations ☹!
- NHSE Shared decision making tools BRAN, 3Qs
- Patient decision aids Patient Decision Aids (PDAs)
- GP evidence https://gpevidence.org

4 Questions to ask to make better decisions together (BRAN)

1. What are the Benefits?
2. What are the Risks?
3. What are the Alternatives?
4. What if I do Nothing ?





Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, Cochran N, Frosch D, Galasiński D, Gulbrandsen P, Han PK. A three-talk model for shared decision making: multistage consultation process. bmj. 2017 Nov 6;359:j4891. https://www.bmj.com/content/359/bmj.j4891

Example: tool to discuss risks and benefits of statins for primary prevention https://gpevidence.org

Treatment options:

Statins for the primary prevention of cardiovascular disease

Risk reduction for an individual depends on their baseline cardiovascular risk.

NICE recommends assessing this using the QRISK3 tool.

The figures below relate to the use of atorvastatin 20mg, a "high intensity" statin.

Here, "combined cardiovascular events" means: fatal and non-fatal angina, MI, TIA and stroke.

Benefits | Harms

QRISK score: 10%

Reduce risk of: Combined cardiovascular events

No treatment: 10 people have a cardiovascular event over 10 years

With treatment: 6 people have a cardiovascular event over 10 years

key

ARR 4%
Absolute Risk Reduction

NNT 25
Number Needed to Treat

RRR 37%
Relative Risk Reduction

EXPLAIN STATS

If 100 people with a baseline 10-year risk of cardiovascular disease of 10% take a statin for 10 years, 4 will avoid a cardiovascular event compared with if they hadn't taken a statin

- *Quality of evidence is HIGH*
- *Study population in trials*
  - *mean age 57*
  - *40% female*
  - *ethnicity was only reported in 8 out of 18 trials.*
  - *86% were Caucasian*
- ***Side effects-Muscle** pains and general malaise are sometimes reported with statin use. Most of this (roughly 90%) is due to a nocebo effect- an adverse effect experienced because the patient expects it, rather than as a result of the treatment itself*

Using an approach that looks through the lens of frailty

Tools: e-Frailty index, Clinical Frailty scale, SPICT tool

Patient identification or recognition

Examples of Indicators that a patient is nearing EoL (adapted from SPICT Tool)

1.Surprise Question	❑ 'Would you be surprised if this patient were to die in the next few months, weeks, days?'
2. Look for any general indicators of poor or deteriorating health	❑ Unplanned hospital admission(s) ≥2 in 6mths ❑ Performance status poor or deteriorating (In bed or chair >50% of the day) ❑ Depends on others for care due to increasing physical and/or mental health problems. The person's carer needs more help and support. ❑ Progressive weight loss (>10% last 6mths) remains underweight; low muscle mass ❑ Persistent symptoms despite optimal treatment of underlying condition(s). ❑ The person (or family) asks for palliative care ❑ New diagnosis of progressive life limiting illness ❑ ≥2 or more advanced or complex LTC (multimorbidity)

3. Look for clinical indicators of one or multiple life-limiting conditions	❑ **Dementia/Frailty** o Unable to dress, walk or eat without help. o Eating and drinking less; difficulty with swallowing. o Urinary and faecal incontinence. o Not able to communicate by speaking; little social interaction. o Frequent falls; fractured femur. o Recurrent febrile episodes or infections; aspiration pneumonia.
	❑ **Neurological disease** o Progressive deterioration in physical and/or cognitive function despite optimal therapy. o Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing. o Recurrent aspiration pneumonia; breathless or respiratory failure. o Persistent paralysis after stroke with significant loss of function and ongoing disability
	❑ **Heart/ vascular disease** ❑ **Cancer** ❑ **Respiratory disease** ❑ **Liver disease** ❑ **Kidney disease** ❑ **Other irreversible conditions with poor treatment outcomes**

CLINICAL FRAILTY SCALE

1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
2	FIT	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.
3	MANAGING WELL	People whose **medical problems are well controlled**, even if occasionally symptomatic, but often **not regularly active** beyond routine walking.
4	LIVING WITH VERY MILD FRAILTY	Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.
5	LIVING WITH MILD FRAILTY	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
6	LIVING WITH MODERATE FRAILTY	People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.
7	LIVING WITH SEVERE FRAILTY	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
8	LIVING WITH VERY SEVERE FRAILTY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** Many terminally ill people can still exercise until very close to death.

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/ story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

Clinical Frailty Scale ©2005-2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Case Study 2 discussion

Evidence based deprescribing tools to identify potentially inappropriate medicines (PIMs) in older people

STOPPFrail 2[1] to assist clinicians with deprescribing decisions.

- For **older people with limited life expectancy**
- Emphasizes importance of shared decision making in deprescribing process
- Patients must meet ALL the following criteria:
  1. **Assistance with activities of daily living dependency and/or severe chronic disease and/or terminal illness.**
  2. **Severe irreversible frailty, i.e. high risk of acute medical complications and clinical deterioration.**
  3. **Physician overseeing care of patient would not be surprised if the patient died in the next 12 months**

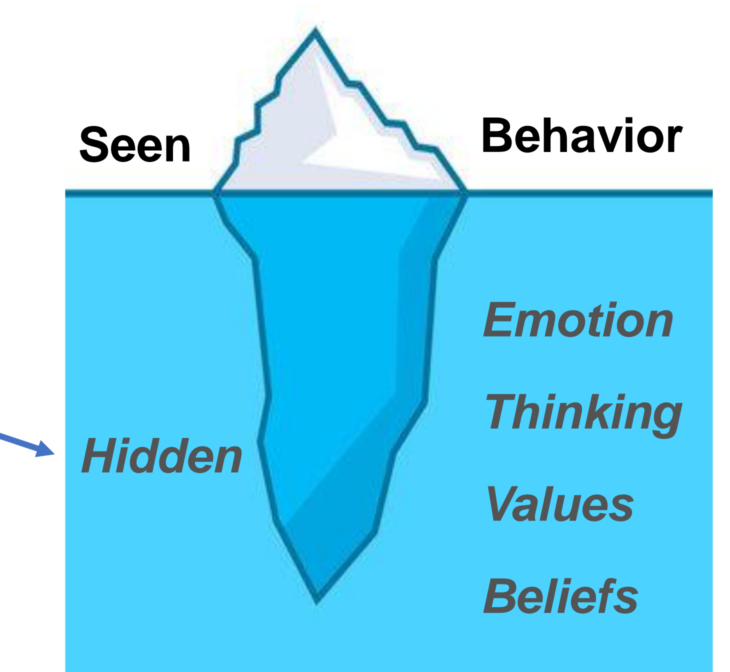
Denis Curtin, Paul Gallagher, Denis O'Mahony, Deprescribing in older people approaching end-of-life: development and validation of STOPPFrail version 2, *Age and Ageing*, Volume 50, Issue 2, March 2021, Pages 465–471, https://doi.org/10.1093/ageing/afaa159

Managing difficult or crucial conversations

Crucial conversation ➡ high stakes, opposing opinions, and strong emotions

A bit about behaviour………

- **RECOGNISE**
  - It is usually not personal
  - There is another agenda (you don't know about)
  - You have an opportunity to change things…..



- **RESPOND**, don't react
- Build **RAPPORT**, find common ground, mind your language
- **LISTEN** to hear, not to defend
- Show **EMPATHY**

5As: ASK➡ ACKNOWLEDGE ➡ ADDRESS ➡ AGREE ➡ ACCEPT

5As Tool to structure difficult conversations

Barnett NL. Improving pharmacy consultations for older people with disabilities. Journal of Medicines Optimisation 2016: Vol **2**:72-76

ASK
give your full attention and don't make assumptions

ACKNOWLEDGE
their situation, show you dont judge them whatever you think

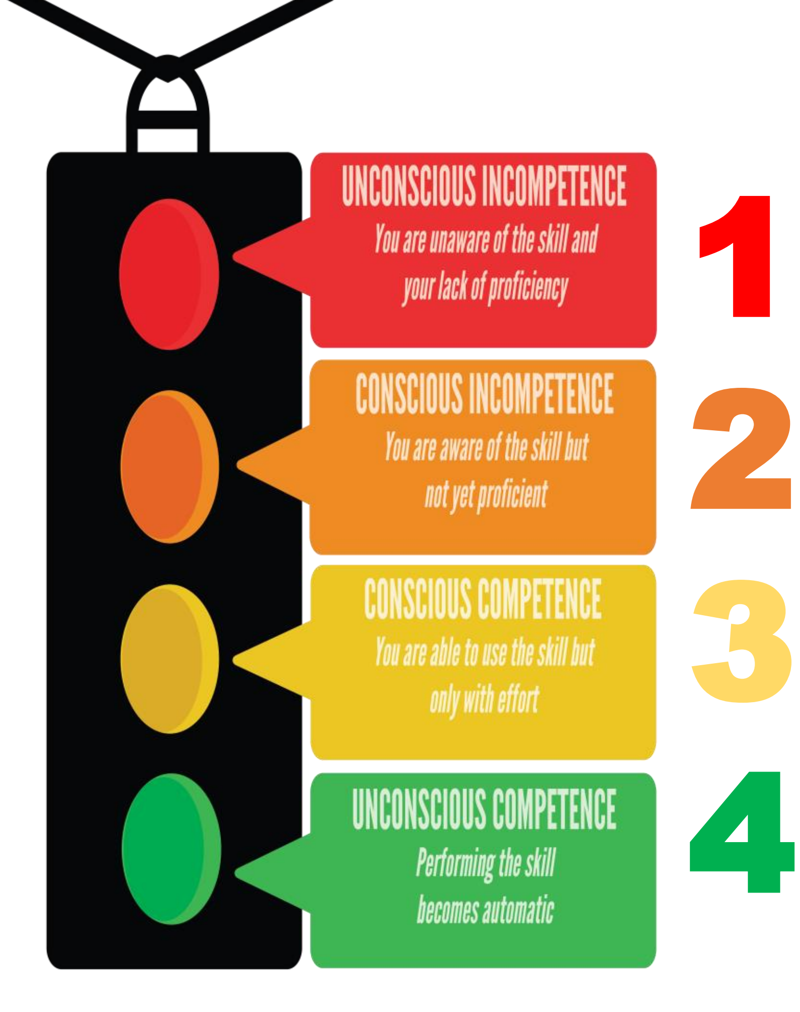
ADDRESS
their issue honestly. Inform of risk/benefit and help available

ACCEPT
their decision even if you dont agree. Leave the "door open"

AGREE ACTIONS
responsiblities monitoring, "safety net" and follow up plan

Thank you for listening

Please rate yourself on how competent are you NOW in the area of (De)Prescribing in older people with frailty multimorbidity and polypharmacy



Hierarchy of competence, Noel Burch 1970