Medication Reviews in Care Homes

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Medication reviews in care homes

- A major study of pharmacist-conducted medication review of all medicines showed that modifications to treatment were needed for half of the medicines prescribed

Furniss L, Craig SKL, Scobie S, Cooke J, Burns A. Medication reviews in nursing homes: documenting and classifying the activities of a pharmacist. Pharm J 1998; 261: 320-323

Medication reviews in care homes

- 47% of recommendations
  - Stop medication
- 2/3 of these cases there was
  - no stated indication for the medicine being prescribed
- Longer-term follow-up showed the number of medicines prescribed for older people can be reduced with no adverse impact on morbidity or mortality

Furniss L, Craig SK, Burns A. Medication use in nursing homes for elderly people. Int J Geriatric Psychiatry 1998; 13: 433-9

Furniss L, Burns A, Craig SK, Scobie S, Cooke J, Faragher B. Effects of a pharmacist's medication review in nursing homes: Randomised controlled trial. Br J Psychiatry 2000; 176: 563-7

Focus Areas

1. Patient
2. Medication
3. Prescribing practice

Patient

- Patient/carers wishes
- Compliance
- Drug administration
- Symptom control
- Physical and cognitive function
- Health changes
- Frailty

Medication

- Is there a current and valid indication
- Risk versus benefit
- Inappropriate long-term prescribing
- Actual/potential drug interaction or toxicity
- Contra-indications
- Is the regimen appropriate; can it be simplified?
- Test results

Prescribing Practice

- Drugs of limited value
- Duplication of therapy/inappropriate polypharmacy
- Potential drug interaction/adverse effects
- Unmet need or untreated indication
- Potential to optimise therapy, e.g. spacer prescribed if necessary
- Sub-therapeutic dosing
- Dose higher than maximum recommended dose
- Monitoring required

POTENTIAL AREAS FOR DEPRESCRIBING

Antihypertensives

- Why consider stopping – ADR e.g. risk of falls

- If > one antihypertensive is used, stop one at a time, maintaining the dose of the others without change. Restart antihypertensives if BP increases above 90 mm Hg diastolic and/or 150 mm Hg systolic (160 mm Hg if no organ damage).

Antidepressants

- Why consider stopping – commonly started in care home settings. Normally when patient first arrives, can be upsetting and alters mood significantly.
- Speak to patient and carers – get full picture as to the mood of the patient. Stop if ineffective or/and depression was isolated and no previous history prior to being admitted to the care home

Acid suppressants

- Why consider stopping - increased risk of infection including pneumonia and C. difficile. Potential increases in bone fracture rates, hyponatraemia and hypomagnesaemia seen in patients taking long-term PPIs.

- Tapering the dose of an acid suppressant (both PPIs and H2RAs) is recommended because of the risk of rebound hypersecretion of gastric acid.
- A step down approach can be employed for certain patients, alongside recommendations for appropriate trials of antacids or alginates and lifestyle changes. Halve the dose for 4–8 weeks then stop (or step down to a less potent agent).

Bisphosphonates

- Why consider stopping – long term use can cause ADR e.g. osteonecrosis of jaw. Compliance is often poor
- Has treatment been taken for five years or more?
- Do the known possible ADRs outweigh the possible benefits?
- If the patient is at low risk of falls, are these still needed? Prolonged immobility is a risk factor for low bone mineral density. Compliance is often poor. Alendronate can be stopped abruptly without the need for tapering.

Statins

- The decision to stop a statin is based on an assessment of individual benefits and risks.
  - Stopping may be justified in a person at relatively low risk of a cardiovascular event, who is also poorly compliant or experiencing troublesome adverse effects.
  - Statins should be stopped in palliative patients.

Review

- Appropriate dosing
  - Max dose citalopram in elderly 20mg od
  - High dose PPI? Valid indication? Reduce to maintenance dose when possible
  - Dosage adjustments common with reduced eGFR
    - Metformin – stop
    - Allopurinol – dose reduction

Is there a current and valid indication

- Ensure
  - BMI = 29.01kg/m2
- Aspirin
  - No longer indicated for primary prevention

Drugs of limited value

- Quinine Sulphate
  - MHRA (2010) recommends: '…benefits should be assessed around every 3 months'
- Carbocisteine
  - Continue[…]if there is symptomatic improvement (i.e. reduction in frequency of cough and sputum production). (NICE 2015)
  - Aim to reduce dose to 1500mg daily if satisfactory response achieved

Inappropriate long-term prescribing

- Risperidone
  - Not appropriate for dementia residents without history of psychotic disorders
  - Behaviour therapy and symptom management i.e. promethazine (has its own problems e.g. increased anticholinergic burden)
  - If on low dose – less than 1mg per day – can be stopped without gradual tapering of the dose

Is there a continuing need?

- Oxybutinin
  - Now catheterised
  - Solifinacin can be used if associated with bladder spasms
  - Otherwise, stop

Anything else…

Common interventions

1. Duplication of therapy – Fostair & Symbicort
2. Aspirin for primary prevention
3. PPIs without established indication
4. Dose adjustments based on eGFR
5. High dose PPIs without review dates
6. Folic acid long-term without monitoring
7. Incontinence meds for catheterised patients
8. Oral nutritional supplements
9. Inappropriate dosing in elderly – e.g. citalopram, digoxin
10. Medicines that contribute to falls risk

Covert prescribing

Clinical support by body system

Find a resource

- Brain and mental health
- Ophthalmology and ENT
- Respiratory and Smoking
- Cardiovascular and Lipids
- Endocrine and Diabetes
- Gastroenterology
- Renal, Urology and Mens Health
- Women's and Sexual Health

Medicines Management

- Medicine Management -useful contacts
- Area Prescribing Committee
- Newsletters
- Traffic Light System
- NICE TA's
- Barnsley Area Joint Formulary
- Hospital Medicine information Service
- MHRA Alerts- monthly Drug Safety Update
- Patient Group Directions (Vaccines)
- Palliative care
- Care Homes
- Domicilary care
- Barnsley Pharmacies list
- Barnsley Local Pharmaceutical Committee LPC
- Inappropriate Prescribing Request Reporting
- Nutrition

Hospital, Primary Care & Social Care Interface

- Barnsley Hospital
- Emergency Admission Criteria ***
- A to Z Services - Contact numbers
- Service directory
- SWYPFT- South West Yorkshire Foundation Trust A to Z service index
- SWYPFT- Service Catalogue
- Social care well-being and community information
- Barnsley Public Health
- Barnsley Housing and Welfare Advice

Commissioning

Working and Appraisal

NHS mail

Care Homes: Management of Medicines prescribing guideline

Due for review
19 July 2016

Cancer, Palliative Care, Pain and Older People

NHS Barnsley CCG in association with Barnsley Metropolitan Borough Council have compiled comprehensive Best Practice guidelines, standards for care and sample documentation for all aspects of Medicines Management in relation to the Care Home setting. They include information on obtaining, storing, administering and maintaining records of medication. These guidelines clarify the responsibilities of commissioners and providers to protect service users against the risks associated with the unsafe use and management of medicines.

The Management of Medicine in Care Homes Guidelines

Additional Resources:-

Principles of Safe & Appropriate Handling of Medicines

Covert Administration of Medication in Care Homes

PLEASE NOTE

Food First information sent to Care Homes

All Care Homes in the Barnsley area have been sent the following information regarding nutrition:

Appendix 2

Covert Medication: GP Flowchart.