Polypharmacy and deprescribing - Agreeing treatment goals before prescribing

Treatment goals and discontinuation criteria should be agreed with a patient before initiating a new medicine.[1] Prescribing decisions should be made after engaging patients in shared decision-making.[2,3] The evidence base to support stopping medicines is limited, although this is a growing field of research and expertise, particularly in older people.[4]

Some of the pressures to prescribe have come from targets in the GP contract and recommendations in guidelines, which are population-based. These do not take into account individual variation, co-morbidities, patient preference and expectations. NICE has published a multimorbidity guideline.[5]

Supporting materials are available at: www.prescqipp.info/polypharmacy-deprescribing-webkit

Key recommendations

- Remember, it is easier not to start a medicine than to stop it, unless both prescriber and the patient are full partners in the decision.[6] Continuing to prescribe may harm a patient.
- Have the discussion about both starting and stopping a medicine before initiation to avoid any surprises in the future.[1]
- All patients (and if necessary their family/carer) should be offered the opportunity to be involved in prescribing decisions, although not all will wish to participate.[2]
- Consider the patient's beliefs, cultures and values, they may be different from those of a health care professional.[3]
- To help understanding, use patient decision aids or option grids, where they exist, in the consultation.[7,8]
- For self-limiting conditions, agree a treatment plan and stop date, the medicine can be restarted if symptoms return, but should not be an open-ended prescription.[1]
- Non-pharmacological options may be chosen for appropriate patients.[1]

Stopping (or not initiating) criteria

Patients should be aware of the expected outcome of a new medicine and what will happen if this is not reached, or reduces in the future.

One of the key reasons for not initiating medicines in older people includes avoiding adverse effects (AE). The aim of any treatment is to prevent morbidity and maximise quality of life, the appropriate use of medicines is essential.

Starting criteria

Before prescribing a new medicine think about the patient's adherence, acceptable pill (medicine) burden, effect on their quality of life, time to benefit, increasing frailty, harm to benefit profile and any alternatives.

However:

- Avoid under prescribing, especially in older patients.
- Don't overestimate the risks and underestimate the benefits of preventative therapies.
- Older people have the highest absolute baseline risk of poor outcomes. They have the most to gain from treatment.

Starting a medicine may be entirely appropriate, but there are some rules to consider:

1. Prescribe the best medicine combination to treat the underlying disorder(s), not necessarily the symptoms of the disorder(s).
2. Choose medicines that are less likely to cause adverse reactions.
3. Start medicines that prevent morbidity, but remember that some people will benefit from lifestyle advice alone.
4. Do not use chronological age as a guide for assessing potential benefit or risk of a medicine.
5. Regularly review the indications for each therapy.
6. Do not change things that are working well.
7. Consider the patient's wishes in treatment decisions.
8. Add a review date and a stop date if this is a short treatment, ensure they are adhered to.
9. Record the current level of frailty.
10. Reduce any potential for medicine interactions.
11. Simplify the prescription regimen whenever possible.

References

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Additional resources available: https://www.prescqipp.info/resources/category/343-polypharmacy-agreeing-treatment-goals-and-discontinuation-criteria

 Bulletin

 Patient information leaflet

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