NHS
Camden
Clinical Commissioning Group

# Camden Prescribing Guidance

# Polypharmacy and Deprescribing Review

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**Agreed by: Camden Medicines Management Committee (CMMC) – June 2018**

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**Working with the people of Camden to achieve the best health for all**

**Camden CCG Summary – Polypharmacy and Deprescribing Review**

This review is applicable to **ADULT** patients only. The aims of this review are to support prescribers to:

- Identify patients who may not be obtaining optimal benefit from their medicines, particularly those patients with multimorbidity.
- Review medication and improve patients' quality of life whilst maintaining control of chronic conditions; this may include stopping, starting or changing a patient's medication.
- Ensure patients are given opportunities to discuss their values, priorities and goals leading to the development of individualised management plans which are reviewed and updated as needed.
- Conduct comprehensive face-to-face clinical medication reviews in identified patient cohorts with a focus on reducing harm and maximising benefit from medicines by addressing multimorbidity and inappropriate polypharmacy and giving consideration to stopping or withdrawing inappropriate or ineffective medicines.
- Reduce wastage of medicines.

***Prescribing Improvement Tips***

***Summary of tips to ensure appropriate polypharmacy***

- Refer to the PrescQIPP Ensuring Appropriate Polypharmacy Tool (Appendix 2) to support decision making at different stages of prescribing and medication review.*
- Before prescribing any new medicine consider (see **Appendix 2**):
  - if the patient has appropriate or inappropriate polypharmacy
  - if the patient has developed a negative prescribing cascade
  - their life expectancy
  - any change in their frailty (both increasing and decreasing)
  - time to benefit from the new medicine
  - net benefit and magnitude of benefit of new medicine
  - risk vs. benefit
  - non-pharmacological options
- Discuss both starting and stopping criteria, there should be no surprises in the future if outcomes are not achieved or maintained.
- Regularly review the outcomes of both new and old treatments and alter therapy as needed.
- Use Table 1 – suggested medicines to consider for review/trial discontinuation and the associated EMIS searches set up to identify patients suitable for a medication review.
- Practices may also wish to review patients who are taking 10 or more medicines. When reviewing this patient cohort, practices may wish to prioritise the following patient groups - patients who have multimorbidity and/or frailty, patients with learning disabilities and/or autism, as these patient groups may be at a greater risk of inappropriate/problematic polypharmacy.
- Ensure adequate, dedicated time is set aside to undertake a medication review. This may vary from patient to patient depending on the number of medicines they are taking and their co-morbidities.
- Reviews can be undertaken over several appointments tackling issues separately.
- Use the EMIS template for medication reviews to support the review. This is available in the suite of locally enhanced services (LES) clinical templates on the EMIS clinical system.
- Consider who can undertake an effective medication review, it does not always need to be the GP; it can be undertaken by an appropriately trained and competent allied healthcare professional.
- Ask the patient what is the most important outcome for them to achieve and use shared decision making where appropriate.
- Follow the suggested deprescribing review process (Figure 1) .
  - Assess patient's needs.
  - Define context and overall goals and an approach that takes into consideration multimorbidity.
  - Identify all potentially inappropriate medicines.
  - Assess risks and benefits in context of the individual patient and discuss with the patient to identify the actual inappropriate drugs and priorities to review.
  - Agree actions to stop, withdraw, 'trial without' or continue medication.
  - Communicate with other relevant parties as appropriate.
  - Monitor the patient regularly and review and adjust management as needed.
  - When discussing the possibility of deprescribing with the patient and/or their carer, the use of alternative language such as '*helping you to take the right medicines for you'* or *'consider a trial without'* may be beneficial to the patient's understanding.

* A level 3 clinical medication review face-to-face with the patient and with access to full clinical notes is considered to be the gold standard and covers all aspects of the patient's prescription, self-care, plus their ability to manage their medicines to maximum effect. Key components include: pre-planning and advance warning for the patient; patient's understanding of treatment; review of physiological tests and measurements; review of efficacy; side effects & interactions; practicalities of medicine usage; future treatment plans; opportunities for questions & concerns. [22, 23]

*Please note this prescribing summary should be read in conjunction with the full prescribing advice and information contained in this document – it is not intended to be read as a standalone message and should not be used as the sole basis for your clinical decisions.*
*The information contained in this document does not override the individual responsibility of the clinician to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.*

***If you are using this guidance document for the purposes of completing a Prescribing Quality Scheme (PQS) marker, then please refer to the accompanying workbook and PQS main information document for that particular scheme year, for details of any targets / and or reviews set and how prescribing performance will be analysed.***

**Background**

Medicines are used to prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare. Ensuring that patients obtain the best outcomes from their medicines is becoming increasingly important because more people are taking more medicines.[1] Data from NHS Digital shows that between 2007 and 2016 the average number of prescription items per year for any one person in England increased from 15.5 (in 2007) to 20 (in 2016).[2] It has also been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1] Optimising medicines use and reducing wastage of medicines is therefore a priority for the NHS.

**Multimorbidity** is associated with reduced quality of life, higher mortality, polypharmacy and high treatment burden, higher rates of adverse drug events, and much greater health services use (including unplanned or emergency care).[3]

**Polypharmacy** in people with multimorbidity is often driven by the introduction of multiple medicines intended to prevent future morbidity and mortality in individual health conditions. However, the absolute benefit gained from each additional medicine is likely to reduce when people are taking multiple preventative medicines, while the risk of harms increases.[3]

Resources and screening tools are available to help guide decision-making about the appropriateness of prescribing and stopping medicines (**Deprescribing**) where inappropriate or ineffective.

This guidance is intended to support clinicians in developing an individualised, person-centred approach to reviewing people with multimorbidity and/or polypharmacy, in line with the NICE guideline on multimorbidity. This may be included in local education and support initiatives to assist shared decision making in individualising care.

## Multimorbidity

The NICE guideline (NG56) on multimorbidity: clinical assessment and management[3] published in September 2016 explains that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include:

- Defined physical and mental health conditions such as diabetes or schizophrenia
- Ongoing conditions such as learning disability
- Symptom complexes such as frailty or chronic pain
- Sensory impairment such as sight or hearing loss
- Alcohol and substance misuse

Measuring the prevalence of multimorbidity is not straightforward because it depends on which conditions are counted. However, all recent studies show that multimorbidity is common, becomes more common as people age, and is more common in people from less affluent areas. Whereas in older people multimorbidity is largely due to higher rates of physical health conditions, in younger people and people from less affluent areas, multimorbidity is often due to a combination of physical and mental health conditions (notably depression).[3]

A particular issue for health services and healthcare professionals is that treatment regimens (including non-pharmacological treatments) can easily become very burdensome for people with multimorbidity, and care can become uncoordinated and fragmented.

The NICE guideline on multimorbidity[3] advises considering an approach to care that takes account of multimorbidity if the person requests it or if any of the following apply. They:

- Find it difficult to manage their treatments or day-to-day activities
- Receive care and support from multiple services and need additional services
- Have both long-term physical and mental health conditions
- Have frailty or falls, See NICE pathway; preventing falls in older people[4]
- Frequently seek unplanned or emergency care
- Are prescribed multiple regular medicines

NICE published a quality standard (QS153) on multimorbidity (June 2017) to support the NICE guideline NG56. It describes high-quality care in priority areas for improvement as follows: [5]

- **Quality statement 1** - **Adults with multimorbidity are identified by their GP practice.**
  - Identifying all adults with multimorbidity is the first step towards finding those who may benefit from an approach to care that takes account of multimorbidity. Multimorbidity is often associated with reduced quality of life, higher mortality, polypharmacy and high treatment burden, higher rates of adverse drug events, and much greater health services use. Some people with multimorbidity have conditions that significantly affect their everyday functioning. Some people find that managing their care is burdensome and involves a number of services working in an uncoordinated way.
- **Quality statement 2** - **Adults with an individualised management plan for multimorbidity are given opportunities to discuss their values, priorities and goals.**
  - A person's values, priorities and goals can affect how they experience long-term health problems and how these affect their life. They can also affect their need for care and support. Discussing and exploring what is important to a person with multimorbidity, recording this in their individualised management plan, and sharing the information can ensure that the planning and delivery of care reflects personal preferences. A person's circumstances may change, so values, priorities and goals should be reviewed and updated.
- **Quality statement 3** - **Adults with an individualised management plan for multimorbidity know who is responsible for coordinating their care.**
  - Managing multiple long-term conditions can be difficult because of the complexity of the conditions and treatment options. An individualised management plan helps ensure that decisions about optimising treatment take account of a person's preferences, needs and priorities; and that the resulting actions are clear. A key aspect is agreement between the person with multimorbidity and the healthcare professional about who is responsible for coordinating care. It is important that the person feels comfortable with the decision and that this information is clearly recorded in the management plan. This can then be shared with healthcare professionals, a partner, family members and carers.
- **Quality statement 4** - **Adults having a review of their medicines and other treatments for multimorbidity discuss whether any can be stopped or changed.**
  - Once preferences and priorities have been explored and any burdens of treatment understood, a healthcare professional and patient can review medicines and other treatments and consider whether they are serving a person's interests. This review might lead to treatments being stopped or changed, or new treatments being started. A family member, friend, or independent advocate may help a person to explain their preferences and better understand their choices. Discussions should include agreement on how frequently future reviews should happen to take account of changes in circumstances.

**Multimorbidity review principles**[3]

| | |
|---|---|
| **Step 1** | **Discuss the purpose of an approach to care that takes account of multimorbidity** |
| **Step2** | **Establish disease and treatment burden** |
| **Step 3** | **Establish patient goals, values and priorities** |
| **Step 4** | **Review medicines and other treatments taking into account evidence of likely benefits and harms for the individual patient and outcomes important to the person** |
| **Step 5** | **Agree an individualised management plan including agreed actions to stop, withdraw, 'trial without', change or continue medication** |

1. **Discuss the purpose of an approach to care that takes account of multimorbidity**
   Discuss with patient that the purpose of this approach to care is to improve quality of life. This might include reducing treatment burden and optimising care and support by identifying:
   - Ways of maximising benefit from existing treatments.
   - Treatments that could be stopped because of limited benefit.
   - Treatments and follow-up arrangements with a high burden.
   - Medicines with a higher risk of adverse events e.g. falls, gastrointestinal bleeding, acute kidney injury.
   - Non-pharmacological treatments as possible alternatives to some medicines.
   - Alternative arrangements for follow-up to co-ordinate or optimise the number of appointments.

**2. Establish disease and treatment burden**

- Establish disease burden by talking to people about how their health problems affect day-to-day life. Include discussion of: mental health, how disease burden affects their wellbeing and how their health problems interact affecting their quality of life.
- Establish treatment burden by talking to people about how treatments for their health problems affect day-to-day life.
  - The number and type of healthcare appointments a person has and where these take place,
  - The number and type of medicines a person is taking and how often,
  - Any harms from medicines,
  - Non-pharmacological treatments such as diets, exercise programmes and psychological treatments,
  - Any effects of treatment on their mental health or wellbeing.
- Be alert to the possibility of: depression and anxiety and chronic pain.

**3. Establish patient goals, values and priorities**

- Clarify with the patient whether and how they would like their partner/family members/carers to be involved in key decisions about management of their conditions. Review this regularly.
- Encourage people with multimorbidity to clarify what is important to them, including personal goals, values and priorities. These may include:
  - Maintaining independence
  - Undertaking paid or voluntary work, taking part in social activities and playing an active part in family life
  - Preventing specific adverse outcomes e.g. stroke
  - Reducing harms from medicines
  - Reducing treatment burden
  - Lengthening life
- Explore the person's attitudes to their treatments and potential benefits and harms of those treatments.

**4. Review medicines and other treatments**

- When reviewing medicines and other treatments, use the database of treatment effects to find information on the: effectiveness of treatments, duration of treatment trials, populations included in treatment trials.
- Consider using a screening tool e.g. the **STOPP/START** tool in older people, to identify medicine-related safety concerns and medicines the person might benefit from but is not currently taking.
- When optimising treatment, think about any medicines or non-pharmacological treatments that might be started as well as those that might be stopped.
- Ask the person if treatments intended to relieve symptoms are providing benefits or causing harms. If the person is unsure of benefit or is experiencing harms: discuss reducing or stopping the treatment or plan a review to monitor effects of any changes made.
- Take into account the possibility of lower overall benefit of continuing preventive treatments that aim to offer prognostic benefit, particularly in people with limited life expectancy or frailty.
- Discuss with people whether they wish to continue treatments which may offer them limited overall benefit.
- Discuss any changes to treatments that aim to offer prognostic benefit with the person taking into account:
  - Their views on the likely benefits and harms from individual treatments,
  - What is important to them in terms of personal goals, values and priorities,

**5. Agree an individualised management plan**

Agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include:

- Starting, stopping or changing medicines and non-pharmacological treatments,
- Prioritising healthcare appointments,
- Anticipating possible changes to health and wellbeing
- Assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services
- Other areas the person considers important to them
- Arranging a follow-up and review of decisions made
- Timing of follow-up and how to access urgent care.
- Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (e.g. healthcare professionals, a partner/family members/carers).

## Polypharmacy

Polypharmacy is a term that has been used in reference to either the prescribing or taking of many medicines, and for many years the term polypharmacy has been used in reference to the prescription or use of more than a certain number of medicines.[6] More recently, polypharmacy has been used in reference to prescribing or taking more medicines than are clinically required because the number of medicines taken, may not always be indicative of potential medication-related problems in the individual patient.[6]

The evidence for national recommendations and guidelines on single health conditions is often drawn from people without multimorbidity who are participating in studies and who are taking fewer regular medicines. The absolute benefit made by each additional medicine is likely to reduce when a person is taking multiple preventative medicines; often referred to as the law of diminishing returns. However, the risk of harms is likely to increase with additional medicines being taken.[3]

The King's Fund report (2013), and the Scottish Government Polypharmacy Model of Care Group guidance (2018) on polypharmacy recognise that not all polypharmacy is inappropriate.[7,8] The King's Fund report on polypharmacy and medicines optimisation highlighted that polypharmacy may be either appropriate or problematic[7]

- **Appropriate polypharmacy** - prescribing for a person for complex conditions or for multiple conditions in circumstances where medicines use has been optimised and where the medicines are prescribed according to best evidence.[7]This has been defined as being present when:[8]
    - *"All drugs are prescribed for the purpose of achieving specific therapeutic objectives that have been agreed with the patient.*
    - *Therapeutic objectives are actually being achieved or there is a reasonable chance that they will be achieved in the future.*
    - *Drug therapy has been optimised to minimise the risk of adverse drug reactions (ADRs) and*
    - *The patient is motivated and able to take all medicines as intended."* [8]

- **Problematic polypharmacy** – the prescribing of multiple medicines inappropriately, or where the intended benefit of the medicines are not realised.[7] This is said to be present when one or more drugs are prescribed that are not or no longer needed, either because:[8]
    - *"There is no evidence based indication, the indication has expired or the dose is unnecessarily high.*
    - *One or more medicines fail to achieve the therapeutic objectives they are intended to achieve.*
    - *One, or the combination of several drugs cause unacceptable ADRs, or put the patient at an unacceptably high risk of such ADRs; or*
    - *The patient is not willing or able to take one or more medicines as intended."* [8]

Therefore, problematic polypharmacy may arise if medicines are used without a good evidence base for doing so, or if (taking into account the person's views and preferences) the risk of harm from treatments is likely to outweigh the benefits, or where one or more of the following apply: [7]

- The medicine combination is hazardous because of interactions
- The overall demands of medicine-taking, or 'pill burden', are unacceptable to the person
- These demands make it difficult to achieve clinically useful medicines adherence
- Medicines are being prescribed to treat the side effects of other medicines, but alternative solutions are available to reduce the number of medicines prescribed.

Problematic polypharmacy may be associated with increased adverse drug events, hospital admissions, increased healthcare costs and non-adherence.[6]

## Deprescribing

World-wide research has shown the value of regular medication reviews to optimise medicines use and reduce the risk of adverse effects. A NICE Quality Standard on medicines optimisation (QS120) published in 2016, recommends that local healthcare providers identify people taking medicines who would benefit from a structured medication review.[1] The medication review may include tapering, withdrawing and discontinuing medicines to reduce problematic polypharmacy, adverse effects and inappropriate or ineffective medication use; this process is called 'deprescribing'.[9] This involves re-evaluating the ongoing reasons for, and effectiveness of medication therapy. The aim of deprescribing should be to reduce medication burden and harm, while maintaining or improving quality of life.[10]

It is important for clinicians to be aware that deprescribing is part of good prescribing; it is a planned and supervised process of dose reduction or stopping of medication that might be causing harm, or no longer be of benefit, backing off when doses are too high, or stopping medications that are no longer needed.[11]

It is essential that all prescribing decisions are fully discussed with the patient and their family/carer (where appropriate), including the decision to stop or withdraw medication.[12] For deprescribing to be undertaken safely, assessment of the individual patient's needs is required, and withdrawal of medication should be a planned and structured process.[13] Consider reducing or stopping one medicine at a time, which makes it easier to identify which medicine is the likely cause if problems develop upon the withdrawal. Close monitoring of the patient is recommended for outcomes of deprescribing to avoid worsening of the clinical condition or undesirable withdrawal effects.[9, 13] All changes to medication must be clearly communicated to the patient and/or their carer and documented in the notes.[9]

**Legal implications of deprescribing** [14, 15]

There is a lack of evidence-based guidance for deprescribing. Prescribers may be reticent to deprescribe, as they are wary of the potential medicolegal consequences if the decision to stop a medicine causes or contributes to an adverse event, or where there may be an evidence-based guideline recommending its use.[14, 15]

When considering potential for litigation in deprescribing, the concepts of **clinical negligence** and **consent** need to be understood in the context of deprescribing.[14, 15]

A healthcare professional is open to a claim of ***clinical negligence*** if their actions fall below the reasonable standard of their peers i.e. there has been a breach of duty. In the UK, the test to assess the appropriate standard of reasonable care is known as the **'Bolam test'** (from the Bolam v Friern Hospital Management Committee case [1957]). The legal test for clinical negligence consists of the following 4 elements:

- **Duty of Care** } **All 4 elements**
- **Breach of Duty** } **are necessary, and**
- **Harm** } **must be established for a**
- **Causation** } **clinical negligence claim.**

Apart from, or in addition to, a claim in clinical negligence, a healthcare professional is open to a claim based on failure to obtain appropriate ***informed consent***. Recent case law has changed the rules and obligations in relation to informed consent in the UK. This is outlined in the Supreme Court decision of Montgomery v Lanarkshire Health Board [2015]. To satisfy the criteria of informed consent, a prescriber must take reasonable care to ensure that the patient is made aware of any ***material risks*** of a proposed intervention, however small that risk may be, and be made aware of **reasonable** alternative or variant treatments.[14, 15] The test of materiality is judged from the perspective of that particular patient, in those particular circumstances.[14, 15]

- **Duty of Care** } **All 4 elements**
- **Lack of informed consent obtained for procedure/treatment** } **are necessary, and**
- **Harm** } **must be established for a**
- **Causation** } **lack of informed consent claim.**

Experience suggests that both prescribing and deprescribing would lead to similar claims of litigation and the same legal tests would apply (in the UK).[14, 15]

It should be noted that all decisions made by prescribers have the potential to confer benefit but equally all decisions entail risks.

In order to optimise safe practice, a prescriber should always consider two aspects of their actions: [14]

- To avoid a claim of negligence, prescribing decisions must be evidence based and/or in line with the decisions of a reasonable body of their peers.
- To ensure full informed consent, a prescriber must discuss clinically appropriate options with the patient, outlining all the materials risks relevant to that patient and advise of appropriate alternatives.

Patient consent to stop, start, change or reduce medication must be based on full disclosure of all material risks to that patient. All prescribers are encouraged to consider discussing the risks and benefits of continuing a medicine and the options for deprescribing at the time of prescribing and throughout the patient journey.[15] In the absence of deprescribing guidance as part of evidence-based guidelines, use of deprescribing tools (e.g. The STOPP START[16,17] and IMPACT[18] medication review tools) are encouraged to support safe practice and improve clinical outcomes.[15] When deprescribing is undertaken in partnership with patients, supported by the knowledge, skills and experience of both patient and clinicians and the patient's values and preferences based on clinical skill, judgement and evidence-based medicine, the law presents no barriers to deprescribing.[15]

The medication review, deprescribing process, multimorbidity review and shared decision making principles detailed in this guidance document support patient centred conversations in the context of structured patient review to ensure the legal aspects of deprescribing have been satisfied.

## Deprescribing review principles

Practices may wish to follow the steps outlined in Figure 1 below, when discussing the possibility of deprescribing with the patient and/or their carer, the use of alternative language such as '*helping you to take the right medicines for you'* or *'consider a trial without'* may be beneficial to the patient's understanding.[13]

*Figure 1: Adapted from: A patient centred approach to polypharmacy by N Barnett, L Oboh, K Smith, NHS Specialist Pharmacy Service,* 2015.[6]

1. **Assess patient's needs:** The purpose of this is to identify medicines related problems and establish the patient's perspective and priorities regarding their medicines. Relevant areas to cover include:[6]
    - Finding out what medicines matter to the patient and any problems they might be experiencing with their medicines.
    - Obtaining functional history from patient and/or carer
    - Medicines reconciliation to establish what the patient is taking and how.[1]

2. **Define context and overall goals:** The purpose of this is to find out how medicines use fits in with or impacts the patient's overall health goals with respect to the patient's functionality, life expectancy and frailty.[6]
    - Obtain medical, social and drug history from available health records
    - Do they have a shortened life expectancy or are they frail?
    - Based on your assessment in Steps 1 & 2 agree with the patient (and/or their family/carer where appropriate) the medicine-related issues/benefits to be addressed during the review.

3. **Identify all potentially inappropriate medicines from an accurate list of medication:** The purpose of this is to consider all the medicines the patient is taking in relation to the best available clinical evidence and in relation to the patient perspective[6] **Please refer to Table 1 in Appendix 1**

4. **Assess risks and benefits in the patient context and discuss with patient to identify the actual inappropriate drugs and priorities to review:** The purpose of this is to confirm or refute the inappropriateness

of each drug identified in Step 3 based on the individual patient priorities and any immediate clinical priorities. This might include the following:[6]

- Identifying any new symptoms/conditions, and reviewing them in relation to when the medication was started.
- Asking about conditions which are active/inactive, time bound or resolved.
- Checking if there is a valid indication for each medication
- Assessing the risks versus benefits the patient may be obtaining from their medication.
- Ensuring that each medication is tailored to the patient's circumstances, clinical and social situation and co-morbidities. Consider patient preferences and ability to adhere to the agreed regimen.

5. **Agree actions to stop, withdraw, 'trial without' or continue medication:** Medicines may be considered for stopping or withdrawal if:[19]
    - There is no valid or relevant indication for prescribing as assessed by changes in symptoms, signs, and laboratory and diagnostic test results.
    - Possible risks outweigh the possible benefits.
    - There is a risk of cumulative toxicity if certain medicines are taken together.
    - Intentional non-compliance where the patient is choosing not to take their medicines as prescribed.
    - Non-drug measures can provide benefit without adverse effects.

**Document a written summary of the review in the clinical notes including rationale, agreed actions and monitoring. A copy should be given to the patient.**

6. **Communicate with other relevant parties as appropriate:** The purpose of this is to facilitate the implementation of medication-related actions and ensure support from all relevant parties. A written summary of agreed actions for each drug change and monitoring should be shared with other relevant parties including community pharmacist, social care, allied health professionals, care home staff and hospital clinicians as needed.

7. **Monitor the patient regularly and review and adjust management as needed.**[6]

When embedding these principles into a review, ensure that any prescribing decisions made are an informed partnership between the healthcare professional and the patient. Consider what the patient wants to achieve before prescribing, discuss alternative options, agree stopping criteria, monitor outcomes regularly and deprescribe when appropriate.[19, 20]

## Medication review

Medication review has been defined as "a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste." [12]

The General Medical Council's (GMC) good practice guidance on prescribing and managing medicines advises that whether medicines are prescribed on a repeat or one-off basis, suitable arrangements must be in place for monitoring, follow-up and review, taking account of the patient's needs and any risks arising from the medicines.[21] The GMC guidance states that reviewing medicines is particularly important where: [21]

- The patient may be at risk, for example, patients who are frail or have multiple conditions.
- Medicines have potentially serious or common side effects.
- The patient is prescribed a controlled or other medicine that is commonly abused or misused.
- The BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals.

Different levels of medication review have been described depending on the amount of information available to the healthcare professional undertaking the review as well as whether the patient is present at the review or not. These are: [22]

- Level 1: a technical prescription review looking at the list of medicines a patient is prescribed.
- Level 2: a treatment review looking at the patient's prescribed medicines with their full clinical notes available to the healthcare professional undertaking the review (not necessarily with the patient present)
- **Level 3: a clinical medication review of medicines and conditions face-to-face with the patient and with access to full clinical notes**.

The level 3 clinical medication review is considered to be the gold standard and covers all aspects of the patient's prescription, self-care, plus their ability to manage their medicines to maximum effect.

The key components of a **level 3 – clinical medication review** include: [23]

- Pre-planning and advance warning for the patient
- Patient's understanding of treatment
- Review of physiological tests and measurements
- Review of efficacy
- Side effects & interactions
- Practicalities of medicine usage
- Future treatment plans
- Opportunities for questions & concerns

An effective medication review offers the opportunity to address any inappropriate polypharmacy as well as any concerns that patients may have about their medicines.[19, 22] It can address problematic side effects, ineffective medication and non-evidence based medication choices.

There is an EMIS template for medication reviews which can be used when reviewing patients with multimorbidity and/or polypharmacy. This is available within the suite of locally enhanced services (LES) clinical templates on EMIS and has been developed by the GPIT and MMT.

A patient information leaflet on medication review is available via the following link on the Medicines Management pages of the GP Website.

**Shared decision making**[24]

All prescribing decisions (including starting, stopping, changing or tapering medication) made during consultations are expected to follow a process of shared decision making in which clinicians and patients work together to select options, based on clinical evidence and the patient's informed preferences. The shared decision making process can be divided into three main stages:

- Choice talk - introducing the patient to the fact there are choices they can make about their treatment and management.
- Option talk - describing the options, sometimes using decision aids to help discuss the evidence in terms of potential benefits, risks and consequences.
- Decision talk - helping patients explore their personal preferences and to use these, together with the evidence, to make an informed decision.

There are also opportunities for "Preference talk" throughout the process; exploring what is important to the individual patient in coming to a shared decision.

For patients to play a part in the decision-making process they need reliable, comprehensible information outlining outcomes, risks and uncertainties. Patient decision aids are designed not just to inform patients, but to help them think about what the different options might mean for them and to reach an informed preference.

The shared decision making process is essential in ensuring that the principles of deprescribing and multimorbidity reviews are incorporated within consultations.

A consultation support tool has been developed by PrescQIPP which suggests elements within a consultation that can assist with shared decision making. Please refer to **Appendix 3** for further information.[25]

**Behaviour change**[24]

People's behaviour largely determines their health and their need for health care e.g. how much they eat, exercise and the extent to which they follow medical advice. 60-70% of premature deaths are caused by behaviours that could be changed therefore the need to engage people with adopting positive health behaviours is so important. Below are key concepts and practical ways in which health professionals can help support behaviour changes in people:

- Consider approaches to consultations that support shared decision making.
- Consider sources of self-management support available locally and nationally in order to signpost patients effectively e.g. peer-to-peer support groups.
- Consider promoting preparatory activities that can help patients feel more equipped to participate in collaborative care.
- Consider the resources available via national social marketing campaigns that could support self-management and behaviour change.
- Be aware of both the potential benefits and risks of health apps e.g. any health apps used that are medical devices should carry a CE mark (in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA)).

- Consider how elements of health coaching and motivational interviewing could be incorporated into interactions with patients.
- Find out if there are any initiatives or training programmes offered locally regarding the above concepts.
- Consider adopting the principles of *'Making Every Contact Count' (MECC)*. MECC is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.[26]

PrescQIPP has issued guidance on 'behaviour change' which includes behaviour change related resources, tools and skill development as well as patient decision aid resources. The document can be accessed via this link.

## Suggested Target Population and Medicines for inclusion

There are several resource tools available to support the review of inappropriate polypharmacy and the deprescribing process to optimise medicines use.[3,6,7,8] The Scottish Government Polypharmacy Model of Care Group Guidance[8], the STOPP START[16,17] and IMPACT[18] medication review tools are evidence based resources which identify medication for review with a view to stopping or a trial discontinuation. For the purposes of this PQS indicator, a suggested list of medications/medication groups has been selected from these tools – see Table 1 in Appendix 1. This includes the circumstances to review and considerations to optimise medicines use after checking for a valid indication. It also includes the rationale and supporting evidence for reviewing the medications/medication groups.

**When reviewing patients on the selected medications/medication groups listed in Table 1, practices may wish to prioritise patients who have learning disabilities and/or autism, or multimorbidity who may be at greater risk of inappropriate polypharmacy.**

It is estimated that on an average day in England, between 30,000 and 35,000 adults with a learning disability, autism or both are being prescribed an antipsychotic, an antidepressant or both without appropriate clinical indications.[27] NHS England (NHSE) has stated that there is a need to prioritize reducing the inappropriate use of psychotropic drugs in people with a learning disability, autism or both and GPs have an important role to play in achieving this.[28] NHSE has issued guidance to support this process and this can be accessed via this link.

Multi-morbidity is an important driver of polypharmacy.[3] It is therefore important that appropriate medicines management approaches including deprescribing and multimorbidity review principles are considered in this group of patients so as to optimise their medication and reduce medication-related harm.

Searches to identify patients on the selected medications/medication groups for review have been developed by the GP Clinical Lead for Medicines Management, the MMT and the IT & Systems team and are available for practices to import for use on the practice clinical system.

**As an alternative to reviewing patients on the selected medications/medication groups in Table 1, practices may choose to review patients who are taking 10 or more medicines**. When reviewing this patient cohort, practices may wish to prioritise the following patient groups - patients who have multimorbidity and/or frailty, patients with learning disabilities and/or autism, as these patient groups may be at a greater risk of inappropriate/problematic polypharmacy.

**Palliative care patients should not be included in this review.**

The practice team may want to discuss the adoption of a proactive approach to addressing inappropriate and problematic polypharmacy in the future. This could involve agreeing treatment targets with patients and/or their carer prior to initiating new medication including discussing both starting and stopping criteria.[9] Refer to the PrescQIPP Ensuring Appropriate Polypharmacy Tool (Appendix 2) for further information.

***If you are using this guidance document for the purposes of completing a Prescribing Quality Scheme (PQS) marker, then please refer to the accompanying workbook and PQS main information document for that particular scheme year, for details of any targets / and or reviews set and how prescribing performance will be analysed.***

## Appendix 1 - Suggested Target Population and Medicines for Deprescribing

The selected medicines in Table 1 below have been identified for review or trial discontinuation from a range of resources on deprescribing, including the STOPP START[16,17], and IMPACT[18] medication review tools, and the Scottish Government Polypharmacy Model of Care Group Guidance[8].

**Table 1**: Suggested medicines to consider for review /trial discontinuation [8, 16, 17, 18]

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| **Gastro-intestinal system** | Anticholinergic antispasmodics (hyoscine butylbromide, dicycloverine hydrochloride, propantheline bromide, atropine sulphate tablets) | • How long have they been prescribed for?<br>• Anticholinergics are commonly associated with adverse effects if discontinued suddenly and require slow withdrawal.<br>• Patients with chronic constipation – risk of exacerbation of constipation. | • Avoid long term use of highly anticholinergic preparations; rarely effective and rarely indicated long-term.[8]<br>• Anticholinergic side-effects e.g. constipation, urinary retention, dry mouth, confusion (particularly in the elderly). Refer to BNF for further details of anticholinergic side-effects. [29]<br>• Caution in the elderly (especially if frail) [29], increased risk of anticholinergic side-effects. |
| | Laxatives | • Has previous use of opioid analgesics reduced or stopped? Regular bowel movements occur without difficulty. Patient is eating and drinking and has adequate fluid intake.<br>• In chronic constipation, laxatives can be slowly withdrawn when regular bowel movements occur without difficulty (for example, 2–4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established). The rate at which doses are reduced should be guided by the frequency and consistency of the stools. Weaning should be gradual in order to minimize the risk of requiring 'rescue therapy' for recurrent faecal loading.[30]<br>• For patients who are on laxatives for chronic constipation, it may take several months to be successfully weaned off all laxatives.[30]<br>• If >1 laxatives are used, review and consider reducing and stopping one at a time slowly. Do not stop treatment abruptly. Reduce stimulant laxative first and monitor effect. It may be necessary to also adjust the dose of other laxatives used to maintain regular bowel movements. Restart laxatives if relapse occurs.[30] | • Stimulant laxatives (e.g. senna, bisacodyl) are only licensed for short-term use.<br>• Excessive doses of, or inadequate fluid intake with bulk-forming laxatives can cause intestinal obstruction. Risk of bowel perforation for patients with intestinal obstruction.[30]<br>• Avoid excessive doses of laxatives; leads to diarrhoea and, if prolonged, electrolyte disturbances such as hypokalaemia.[30]<br>• Inadequate fluid intake with lactulose or macrogols can be dehydrating.[30]<br>• See NICE CKS on constipation[30] for further details of when and how to stop treatment. |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| **Cardiovascular system** | Diuretics (Loop) | • Dependent ankle oedema and no signs of heart failure.[17] Loop diuretics are usually essential for symptom control in heart failure but are not indicated for dependent ankle oedema (consider medication causes e.g. calcium channel blockers).[8]<br>• As first line monotherapy for hypertension.[17]<br>• Sudden discontinuation of diuretics may be associated with adverse effects, slow withdrawal may be required.[18] | • No benefit; compression hosiery may be more appropriate.[16,17]<br>• Safer, more effective antihypertensives available.[17] Consider risk of acute kidney injury and electrolyte disturbances.[8] |
| | Peripheral vasodilators (naftidrofuryl, pentoxyfylline) | • Do the known possible risks outweigh the possible benefits? | • Clinical effectiveness often not established.[8]<br>• Rarely indicated for long term use.[8] |
| **Central Nervous System** | Antidepressants | • Single episode of depression, treat for 6-9 months.<br>• Multiple episodes, treat for at least 2 years.<br>• Do not prescribe dosulepin where possible.<br>• Tricyclic antidepressants (TCAs) taken with other anticholinergic medication that can increase cognitive impairment?<br>• Possible side-effects outweigh benefits, e.g. side-effects of TCAs.<br>• The use of antidepressants without appropriate clinical indication in people with a learning disability and/or autism.<br>• When withdrawing antidepressants, reduce dose gradually to avoid withdrawal effects.<br>• The speed of withdrawal is dependent on the length of treatment:< 4 weeks therapy, reduce over 1-2 weeks;>8 weeks reduce over 4 weeks; long term maintenance therapy, reduce over 6 months.[18] It may be possible to stop low-dose fluoxetine immediately due to the long half-life of fluoxetine. However, people taking higher doses (40 mg to 60 mg daily) may require gradual withdrawal.[31, 32] See NICE CKS on depression for further information on stopping antidepressant treatment. | • In the NICE guideline (CG91) on managing depression in adults who also have a chronic physical health problem. NICE recommends reviewing the need for continued antidepressant treatment beyond 6 months after remission, taking into account:<br>o the number of previous episodes of depression<br>o the presence of residual symptoms<br>o concurrent physical health problems and psychosocial difficulties.<br>• The evidence supporting the tolerability of dosulepin relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose.[31, 32] See NICE CG90 on depression in adults.[31] NHS England (NHSE) has also issued guidance on items which should not be routinely prescribed in primary care. [33] The guidance includes the following recommendations on dosulepin:<br>➢ Do not initiate for any new patient in primary care.<br>➢ Identify existing patients on dosulepin and consider deprescribing. (***Please seek specialist advice regarding deprescribing***).<br>➢ If in exceptional circumstances, there is a clinical need for dosulepin to be prescribed in primary care, this should be in cooperation with a specialist. (***Please also contact MMT for latest advice)***.<br>For advice on the management of specific patients who are taking dosulepin, clinicians may contact the Camden Mental Health Assessment and Advice Team (CMHAAT), 4 St Pancras Way, St Pancras Hospital, London, NW1 0PE. |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| | | | Tel: 020 3317 7300, Email: CIM-TR.aat-referrals@nhs.net<br>Always refer to the Camden GP website for up to date contact details of CMHAAT.<br><br>The review of patients taking dosulepin is also covered in the PQS indicator - ***Items which should not be routinely prescribed in primary care.*** Practices who choose to review patients on dosulepin should only do so under one of the two PQS indicators i.e. reviews should not be duplicated.<br><br>• Increased risk of anticholinergic side-effects e.g. constipation, urinary retention, dry mouth, confusion (particularly in the elderly) when TCAs taken in combination with other anticholinergic medication. Refer to BNF for further details of anticholinergic side-effects.[29]<br>• Caution with all systemic anticholinergics in the elderly (especially if frail) [29], increased risk of anticholinergic side-effects.<br>• TCAs can worsen dementia, glaucoma, constipation, urinary retention.[18] SSRIs may induce clinically significant hyponatraemia.[17]<br><br>• **There is a national drive to stop over-medication of people with a learning disability and/or autism (STOMP).** GP practices may wish to prioritise the review of antidepressant use in people with these conditions. It is estimated that on an average day in England, between 30,000 and 35,000 adults with a learning disability are being prescribed an antipsychotic, an antidepressant or both without appropriate clinical indications (psychosis or affective/anxiety disorder).[27, 28] A substantial proportion of people with a learning disability and/or autism who are prescribed psychotropic drugs for behavioural purposes can safely have their drugs reduced or withdrawn.[27, 28]<br><br>• NHS England has published a document to provide GPs and other clinicians with support to begin the process of challenging the continued need for psychotropic drugs (including antidepressants) in people with a learning disability and/or autism.[28] The NHSE document can be accessed via this link. |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| | Anticholinergics in patients on antipsychotics | • When anticholinergics are used to treat extra-pyramidal side-effects of antipsychotic medications.[17]<br>• Are antipsychotics with anticholinergic activity (e.g. chlorpromazine) being taken with other medicines that have anticholinergic activity and increased risk of cognitive impairment e.g. TCAs, oxybutynin, chlorphenamine?[18] | • Anticholinergic side-effects e.g. constipation, urinary retention, dry mouth, confusion (particularly in the elderly). Refer to BNF for further details of anticholinergic side-effects.[29]<br>• Risk of anticholinergic toxicity, including confusion, cognitive impairment and urinary retention. [16,17,18]<br>• Caution with all systemic anticholinergics in the elderly (especially if frail) [29], increased risk of anticholinergic side-effects. |
| | Betahistine, Metoclopramide, Domperidone | • Review indication and ongoing need.<br>• Easy to restart if symptoms return.<br>• Consider reducing betahistine 16mg TDS to 8mg TDS. | • **Betahistine:** Insufficient evidence to say whether betahistine has any effect on Meniere's disease or not. Follow recommendations on the use of betahistine in NICE CKS on Meniere's disease.[34]<br>• **Metoclopramide** can cause extrapyramidal side effects including tardive dyskinesia (↑ risk in older adults with frailty). Metoclopramide should only be prescribed for short-term use (up to 5 days). See MHRA Drug Safety Update on risk of neurological effects with metoclopramide.[35]<br>• **Domperidone** has been restricted to use in the relief of nausea and vomiting. Maximum treatment duration should not usually exceed 7 days due to risks of cardiac side effects. It should be used at the lowest effective dose for the shortest possible time. See MHRA Drug Safety Update on domperidone: risk of cardiac side effects.[36] |
| **Endocrine system** | Oestrogens and progestogens | • No mandatory limitation on duration of hormone replacement therapy (HRT).[18]<br>• Continuation of therapy is dependent on objective estimation of ongoing benefits and risks for the individual patient.[18]<br>• After starting HRT, it is advisable to review after 3 months to assess effect of therapy and enquire about side effects and bleeding pattern.[37]<br>• If systemic HRT is being used for symptom control, consider a trial withdrawal (if a woman is symptom-free) after 1-2 years.[37] | • Evidence of carcinogenic potential in breast and endometrium, lack of cardio-protective effect and cognitive protection in older women.[8,18]<br>• Topical low dose oestrogen intravaginal cream safe and effective in dyspareunia and other vaginal symptoms.[18]<br>• Refer to **Camden Prescribing advice for the management of menopause in primary care** for further advice.[37] |
| | Bisphosphonates | The following recommendations apply to **women only** [38]<br>• Alendronic acid, risedronate and ibandronic acid should be reviewed after 5 years of treatment.<br>• Zolendronic acid should be reviewed after 3 years of treatment. | • Atypical femoral fractures have been reported rarely with bisphosphonate therapy, mainly in patients receiving long-term treatment for osteoporosis; atypical femoral fractures are considered a class effect of bisphosphonates.[40] |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| | | • Patients with no new fracture and femoral BMD T-score > -2.5 can generally have treatment withdrawn.<br>• Certain groups of higher risk individuals* should generally continue bisphosphonate treatment without need for a treatment break.<br>• Following withdrawal of treatment, re-evaluate fracture risk (using FRAX® and femoral neck BMD) and consider restarting treatment after 2 years (alendronic acid, risedronate and ibandronic acid) or 3 years (zolendronic acid).<br>• Fracture risk should be re-evaluated if a new fracture occurs. Further treatment can be with the same bisphosphonate used previously.<br><br>***Higher risk individuals as follows**:[38,39]<br>• Certain groups of individuals can generally continue treatment (beyond 5 years for oral bisphosphonates or 3 years for IV) without further assessment, though review after six years (IV therapy) to ten years (oral therapy) is recommended:[39]<br>  o Age ≥ 75 years<br>  o Previous hip or vertebral fracture<br>  o Low trauma fracture during treatment (with good adherence) and following exclusion of secondary osteoporosis<br>  o Femoral neck BMD T-score ≤ -2.5 SD<br>• Osteoporosis and fractures are a common side effect of aromatase inhibitors (e.g. letrozole). Extended use of aromatase inhibitors (> 5 years) may require additional long-term use of bisphosphonate.[38]<br>• Bisphosphonate treatment will usually be continued without a treatment break for patients taking more than 7.5 mg prednisolone or equivalent daily. FRAX® is likely to underestimate fracture risk in these patients.[38,39] | • The risk of osteonecrosis of the jaw and atypical femoral fractures whilst on bisphosphate treatment has led to questions about the optimal treatment duration for bisphosphonates. It is therefore important to balance the risks and benefits of these medicines.[38,39]<br>• For further details refer to:<br>  o North Central London Joint Formulary Committee (NCL JFC) Position Statement: Bisphosphonate treatment duration in women.[38]<br>  o MHRA Drug Safety Update: Bisphosphonates: atypical femoral fractures.[40]<br>  o NICE guideline on Multimorbidity: clinical assessment and management NG56.[3]<br>• There is insufficient evidence to guide optimal treatment durations in men, therefore these recommendations apply only to women.[38] |
| **Obstetrics, Gynaecology & Urinary Tract disorders** | Alpha blockers | Use not indicated if patient has a long term (>2 month) catheter in situ.[8,18] Slow withdrawal required to minimize adverse effects.[18] | |
| | Overactive bladder (OAB) drugs | • Review effectiveness every 4-6 weeks until symptoms stabilise and then every 6-12 months.[29]<br>• Are continence pads also being used? | • See NICE Guideline (CG171) on urinary incontinence in women: management. |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| | | • Possible side effects (e.g. postural hypotension, urinary retention, constipation) outweigh benefits?<br>• Are antimuscarinics being taken with other medicines that have anticholinergic activity and can increase risk of cognitive impairment (e.g. chlorpromazine, tricyclic antidepressants, and chlorphenamine)?[18] | • Caution with all systemic anticholinergics in the elderly (especially if frail) [29], increased risk of anticholinergic side-effects. |
| **Nutrition & Blood** | Iron supplements | • Do the known possible risks outweigh the possible benefits?<br>• Iron supplements - continue for 3 months after deficiency corrected. Can be stopped without tapering.<br>• No evidence of enhanced iron absorption at elemental iron doses >200mg daily or with vitamin C. [18]<br>• Different iron salts and their elemental iron content are:[29]<br>o Ferrous fumarate 200mg = 65mg elemental iron.<br>o Ferrous gluconate 300mg = 35mg elemental iron.<br>o Ferrous sulphate 300mg = 60mg elemental iron.<br>o Ferrous sulphate, dried 200mg = 65mg elemental iron. | • Is there a valid indication for prescribing? e.g. does the patient have a clinical condition that requires iron supplementation? |
| | Calcium and Vitamin D | • Is there a valid indication for calcium and vitamin D supplementation? [18]<br>• If patient is not mobile, is this still needed?[18]<br>• Cardiovascular risk assessment<br>• Review patients taking calcium or combined calcium and vitamin D supplementation and assess their dietary calcium intake.[41]<br>• Consider stopping calcium supplementation in those with adequate/high dietary intake of calcium (though vitamin D may need to be continued).[41] | • As part of the review, GP practices are advised to undertake a risk/benefit assessment of the use of calcium and vitamin D supplements, taking into consideration the cardiovascular risks that may be associated with the use of calcium and vitamin D supplements. Some evidence suggests that high total calcium intake is associated with raised mortality risk.[41] Targeting calcium supplementation to those who are unable to take adequate levels through their diet is probably more appropriate.[41]<br>• See NCL JFC guidelines on Calcium + vitamin D supplementation for the prevention of osteoporotic fragility fractures. |
| **Musculoskeletal & Joint diseases** | Quinine | • Interrupt treatment at intervals of 3 months to assess continued need. If beneficial, continue for 3 months, then aim to stop treatment to reassess ongoing need. If further treatment is required, review every 3–6 months.[42]<br>• Consider trial discontinuation in long term patients.[42] | • Quinine is generally not recommended for treating idiopathic leg cramps due to the poor benefit-to-risk ratio. There are no clinical trials, which have evaluated the long-term efficacy or safety of quinine use for leg cramps. See NICE CKS on leg cramps at Leg cramps - NICE CKS[42]<br>• An MHRA Drug Safety Update[43] recommends that quinine should not be considered as routine treatment for nocturnal leg cramps, and should only be considered when cramps cause regular disruption of sleep. Before use of quinine for |

| BNF Category | Medication group | Circumstances to review and considerations to optimise medicines use after checking for a valid indication | Rationale |
|---|---|---|---|
| | | | nocturnal leg cramps, the risks should be carefully considered relative to the potential benefits. **Quinine should only be considered:**<br>o when cramps are very painful or frequent.<br>o when other treatable causes of cramp have been ruled out.<br>o when non-pharmacological measures have not worked (e.g. passive stretching exercises).<br>• A 2017 MHRA Drug Safety Update [44] also advised healthcare professionals to:<br>o be aware of dose-dependent effects of quinine on the QT interval and use caution if prescribing quinine in patients:<br>▪ with conditions that predispose to QT prolongation such as pre-existing cardiac disease or electrolyte disturbance<br>▪ taking other medicines that could prolong the QT interval<br>▪ with atrioventricular block<br>o monitor patients closely if administration of quinine with phenobarbital or carbamazepine is necessary; serum levels of these anticonvulsant medicines could become raised and cause anticonvulsant toxicity. |

**In reviewing patients on the medicines listed in Table 1, practices may wish to prioritise patients who have learning disabilities and/or autism, or multimorbidity i.e. two or more long-term conditions (physical or mental health conditions) who may be at greater risk of inappropriate polypharmacy.**

**Appendix 2: PrescQIPP- Ensuring Appropriate Polypharmacy Tool**

## Ensuring appropriate polypharmacy tool

PrescQIPP Community Interest Company

This tool has been designed to support decision making at different stages of the prescribing and medication review. Considerations for each stage are listed and as this resource is further developed will be supported by decision aids and e-learning. The 2015 NHS Scotland Polypharmacy Guidance and the 2014 All Wales Medicines Strategy Group Polypharmacy: guidance for prescribing also offer definitions, examples and guidance to support the headings in this tool.

**Before initial treatment**
Consider:
- Life expectancy
- Frailty
- Time to benefit
- Net benefit
- Magnitude of benefit
- Risk vs. benefit

**Agree treatment targets with patient and/or carer**
Examples include:
- Primary prevention
- Symptom control for acute problems
- Outcome expected
- Stopping criteria
- Required tests

**Consider alternative approaches**
Consider:
- Lifestyle change(s)
- Self care (OTC medicines)
- Non-pharmacological options

**Agree time period of treatment(s)**
Discuss:
- Defined short period with action plan
- Expected outcomes
- Continuation criteria
- Stopping criteria
- Refer to community pharmacy New Medicines Service (NMS)

**Planned re-assessment and Medication Review**
- Assess outcomes vs. expectations
- Continuing response to treatment
- Compliance with dose and frequency
- Dose titration (up or down)
- Change in frailty
- Defined treatment period reached
- Condition resolved

**Agree continuing treatment**
Defined period with review plan
Discuss:
- Expected outcomes
- Continuation criteria
- Stopping criteria
- Need for tests and frequency

**Benefit not achieved**
**Risk increases or benefit decreases**
**Adverse event**
**Defined treatment period reached**
**Condition resolved**
- Stop medicine and remove to history
- Withdraw (possibly re-introduce if non delivery of benefit is due to external factors)

**Discuss treatment options with patient and/or carers**
- Prescribe an alternative if available
- Non-pharmacological alternatives
- Coping strategies
- No further treatment options

**Transferring to End of Life Care**
- Evaluate benefit to the patient of current medications
- Discuss revised treatment objectives with patient and/ or carers
- Exception reporting

*This is an NHS document not to be used for commercal or marketing purposes*

**Appendix 3: PrescQIPP- Consultation support tool - Suggested elements of a consultation to support shared decision making[25]**

| Consultation elements | Example questions |
|---|---|
| **Developing empathy and trust**<br>Ask open-ended questions to invite people to tell their story.<br>Affirmations, normalisation, validation to support patients own perspective.<br>Reflections to build empathy and seek clarification. | 'Tell me about...'<br>'How did your symptoms start?'<br>'It's natural to feel the way you feel.'<br>'Many people I meet tell me a similar story.'<br>'So, what I'm getting from our conversation is that you are most interested in_____. Is that correct?' |
| **Negotiated agenda-setting and prioritising**<br>Invite people to set their agenda before clinicians set theirs. | 'What do you want to talk about in our time together today?'<br>'What questions/concerns do you have?'<br>'There are other things that I'd like to discuss – is that OK?' |
| **Information sharing**<br>Some patients possess incomplete or incorrect information about their condition. Invite them to explain what they already know and/or fear about their condition or symptoms. | 'What do you understand about your condition?'<br>'What do you understand about what is happening in your body when you get your symptoms?'<br>'What concerns or worries do you have about your condition?' |
| **Re-attribution (if appropriate)**<br>Patient beliefs about the cause of their condition or symptoms may be unhelpful or incorrect (misattributed) e.g. believing that angina pectoris is a mini heart attack. These incorrect beliefs tend to predict behaviours, including health care-seeking behaviours.<br>People who have incorrect beliefs should not be told that they are 'wrong', but rather invited to consider an alternative viewpoint | 'Many people who have angina think like that. The evidence is that angina isn't actually a heart attack. Now I have shared that thought with you, what does that mean for you?' |
| **Managing risk**<br>Risk should be framed in a way that is meaningful to patients (and clinicians), such as using absolute (rather than relative), natural frequencies and population-based risks.<br>Well-designed patient decision aids can be of great assistance.<br>'Ask, Tell, Ask' can be used as a simple format for relaying complex information.<br>Strategies for managing risk are important when it comes to clinicians 'trusting' patients to undertake a course of action outside the consulting room (e.g. taking medication at home). It is tempting to 'tell' patients what to do in order to feel in control of the risk. However the approach that supports adherence is one that supports patients to understand and manage risk for themselves.<br>It is recommended that a shared decision-making conversation that results in patients taking responsibility for a course of action at home (e.g. taking a course of medication) formally addresses and documents the issues of risk and responsibility. | Ask: I'd like us to consider the possible benefits of the treatment - is that OK?'<br>Tell: 'Taking medical treatments to lower blood pressure can reduce the chances of having a stroke. Over five years, around 17 in 1,000 people who take drug treatments for high blood pressure will have a stroke. Around 27 in 1,000 people who don't take drug treatments will have a stroke.'[†]<br>Ask: 'What does that mean for you?' |

| Consultation elements | Example questions |
|---|---|
| **Supporting deliberation**<br>It is important to ask people what they want from the treatment or self-management support options and what they know about them.<br>Aspects of the treatment benefits and risks that are important to them, plus any concerns should also be explored. | 'What do you hope you will be able to achieve if the treatment is successful'<br>'What do you know about the treatments/care or support that is available?'<br>'What do you know about the benefits of the possible treatments?'<br>'What concerns do you have about the possible treatments/care/ support options?'<br>'Here are the options we can talk about_____. Where do you want to start?' |
| **Summarising and making the decision**<br>Clinicians should summarise what they have learned and what the patient has learned, pausing occasionally to verify the summary.<br>Emphasis should be given to those aspects of the conversation where patients have clearly articulated their preferences. | 'In summary, you have back pain and you want to do more walking. We have discussed the various options and your preferences and agreed that what is important for you is a treatment with low risks – you told me that it is really important for you to continue to look after yourself since your wife died'.<br>'Given all of this, which treatment should we decide is the right one for you?' or 'Given all of this, is there anything else we should consider before coming to a decision?' |
| **Documenting the decision**<br>There should be a formal system for documenting the decision and agreed course of action. This provides a reference for the patient and clinicians, and shows that choices (along with reliable information) were offered.<br>Where appropriate, the ongoing roles and responsibilities of each party should be documented. | |

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