MEDICINES USE AND SAFETY WEBINAR

- Welcome to the Medicines Use and Safety Team Webinar: Medicines and Frailty with Lelly Oboh
- The webinar itself will start at 1pm – in the meantime Carina Livingstone is doing sound checks – bear with her if you hear this more than once!
- To dial in call 0203 478 5289 access code 950 700 727
- The webinar will be recorded and both recording and slide set will be available on the SPS website – under Networks - https://www.sps.nhs.uk/meetings/a-patient-centred-and-outcome-focused-approach-to-optimise-medicines-use-for-older-people-living-with-frailty/
- If you want to ask a question, please use the “chat” function (you need to choose to direct your question to “All Participants” from the drop down box)
- Questions in the chat box will either be answered during the presentation by one of the speakers verbally or in the chat box by a speaker or MUS Team Member
Upcoming MUS Events

January 11th 2017 - MUS Webinar at 1pm – PGD Update with Angela Bussey, Tracy Rogers and Sandra Wolper
May 16th 2017 – Health and Justice Pharmacy Network Meeting, NCVO, London

Recent publications

Medication Safety Officer Handbook
An essential resource for all MSOs and their managers

Medicines Optimisation in Atrial Fibrillation
Using data to assess the quality of care and a CCG anticoagulation case study
A patient centred and outcome focused approach to optimise medicines use for older people living with frailty

Lelly Oboh
Consultant Pharmacist, Care of older people
NHS Specialist Pharmacist Services
Webinar 14th December 2014
Overview

• Background: Frailty and medicines
• A step by step patient-centred and outcome focused approach to managing polypharmacy as part of optimising medicines use
  – purpose behind each step
  – points to consider
  – questions to ask
  – actions to take
Typical Frail Older Person

Watch Mrs Andrews' Story – what went wrong?
https://youtu.be/I0TVbhHdg4A

• Female, lives alone
• Multimorbidities and polypharmacy
• Higher risks of adverse drug events (ADEs)
• Frequent hospital admissions, longer stays
• Higher users of health and social care
• 10% of over 65s, 25-50% over 85s

What is frailty?

- Age-associated decline in physiologic reserve and function across multi-organ systems leading to increased vulnerability for adverse health outcomes (Fried et al 2001)
Reduced functional reserve in frailty

Fig 1. Frail older people display low resilience to minor stressors (e.g. urinary tract infection). This figure adapted from Clegg A, Young J, Iliffe S, et al. Frailty in elderly people. Lancet 2013;381:753(Figure 1) with permission from Elsevier.
Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – 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, but are not regularly active beyond routine walking.

4 Vulnerable – 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 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People 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 Severely Frail – 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 Very Severely Frail – Completely dependent, approaching the 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 evidently frail.

Scoring frailty in people with dementia

The degree of frailty 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.


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Survival curves using Cumulative Deficit model

Rockwood et al. 2005,
Frailty, polypharmacy and mortality

2350 French older people
• Independent and combined effects of polypharmacy and frailty on mortality risk
• 6x increased risk of death in frailty vs. robust and non polypharmacy (>5 drugs)
• 3x more likely to be on 5 drugs
• 6x more likely to be on 10 drugs

• High risk prescribing (polypharmacy, anticholinergic) can contribute to frailty  (Gnjidic D et al 2012)

Additional practical challenges in frailty

- Disability - More reliant on others for support
- Poor patient engagement and communication
- Multi-morbidities/prescribers
- Multiple individuals/teams involved incl. non clinical staff
- Complex pathways and processes across various organisations
- Monitored dosage systems
Managing polypharmacy and deprescribing
Medicines Optimisation

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

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

The importance of language in managing Polypharmacy..

- Patient and carers view stopping medicines as a cost-cutting exercise!
  
  Cahill. L 2014. PrescQipp Polypharmacy and Deprescribing landscape review

- Polypharmacy
  - “Too many medicines” vs The right amount for you

- Deprescribing
  - “Stopping your medicines” Vs. Trial and review
What’s out there to help?

• **UK guidance** from NHS Scotland, Kings Fund (England), NHS Wales, PrescQIPP NHS Programme

• **Evidence-based tools**

Provide....

• Background and context
  Evidence based framework for optimal use of medicines

• Tools to support safe review
Where is the gap?

The patient perspective!
Preventable Drug Related admissions
(Qual Saf Health Care 2008)

• Problems at multiple stages, multifaceted & complex
• Main causes irrespective of association
  – Communication failures (patients and healthcare professionals, between healthcare professionals)
  – Knowledge gaps (about drugs, patients’ medical and medication histories).

Conclusion
  – Technical solutions unlikely to be sufficient on their own.
  – Interventions targeting the human causes are necessary e.g. improving methods of communication.
Managing polypharmacy in the real world........ Emerging themes

A lot more than just stopping drugs

- Deprescribing (safe withdrawal that considers the patients perspective and experience)
- Need to consider how people are supported to take medicines
- Consultation styles that engage the patient and provide individualised information
- Managing polypharmacy across secondary, primary and social care settings

1. Smith H et al. Review of patients re-admitted post IMPACT pharmacist intervention designed to reduce medicines-related re-admissions. Age & Ageing 2014; 43:i1-i18
Patient-centred approach to managing polypharmacy

1. Identify frail people
2. Assess patient
3. Define context and overall goals
4. Identify medicines with potential risks
5. Assess risks and benefits in context of individual patient
6. Agree actions to stop, reduce dose continue or start
7. Communicate actions with all relevant parties
8. Monitor and adjust regularly


© N Barnett L Oboh K Smith NHS Specialist Pharmacy Service 2015
The patient centred approach to managing polypharmacy

• Each STEP provides practical support for clinicians to embed MO into everyday practice through patient centred, safe, evidence based medication review
  – Points to consider
  – Actions to take
  – Questions to ask
• Prioritise the issues
• Focus on one or a few key concerns
• Emphasises effective communication incl. patient, family/carers and other practitioners
• Ensure changes are actioned and followed up.
Testing the Process (SPS Survey Nov 2015)

- 15 UK clinical pharmacists
- 82 patients, Mean Age: 82 yrs
- Mean no of LTCs: 5
- Care home and domiciliary care settings
- 60 (73%) present at reviews.
- Evidence based tools including STOPP/START and other UK guidance were used
Testing the Process - Results

- Total no of drugs prescribed
- 133 (22%) stopped
- 1.9 drugs reduced per patient.
- Post review follow up was the most challenging step
- Process enabling an understanding of the patient’s experience rated as “very effective” or “effective” in 56 (66%) of reviews.
Identifying & recognising frailty
Preparation for consultation

Often present with frailty syndromes
- Falls
- Immobility
- Delirium
- Incontinence
- **Susceptibility to ADEs**
  - Cognitive impairment
  - Depression
  - Inability to cope- ‘ACOPIA’,

**Post discharge**
- Vulnerable period of increased risks
- Critical 30-day period
- Severity of index illness does not predict readmission
  

- Morbidity and functional disability are most common risk factors for readmission.
  
Improved Consultations

- Encounters moving from giving information to patient led conversations, with shared agenda, shared treatment decisions and joint solutions to problems identified.
Patient centred consultations
The Four E’s (Nina Barnett®)

• **Explore** what the patient wants to know and follow their agenda
• **Educate** them on what they want to know
• **Empower** patients to take responsibility for medicines taking
• **Enable** behavioural change in order for patients achieve their aims

Assess patient’s needs

EXPLORE

• Purpose- to identify medicines related problems and establish the patient’s perspective and priorities including what the patient wants to focus on now
EXPLORE, EDUCATE

• Purpose: to find out how medicines use fits in with or impacts on their overall health goals with respect to patient’s functionality, life expectancy and frailty

• Obtain medical, social and drug history from patient vs information available from health records incl. Medicines Reconciliation

• Based on Steps 1 & 2 agree the medicine-related issues/benefits patient wants addressed at the visit/consultation.
Identify medicines with potential risks

• **Purpose of this is to consider ALL the medicines the patient is taking according to the best available research evidence**

• Use an evidence based tool e.g.
  
  – STOPP/START criteria
  – Anticholinergic Burden Scale
  – GP-GP algorithm *Garfinkel D*
  – CRIME *Drug & Ageing 2014 Italy*
  – Single disease database *NICE Multimorbidity NG56 2016*
Assess risks and benefit in the patient context

EXPLORE, EDUCATE,

• Purpose: to confirm or refute the inappropriateness of each drug identified in Step 3 based on the individual patient priorities and any immediate clinical priorities.

• To ensure that EACH medicine is tailored to the patient’s circumstances, clinical and social situation and co-morbidities
Summary: Assess needs and review therapy

EXPLORE, EDUCATE

• Gather relevant information
• Medicines reconciliation
• Agree joint agenda
• Patient’s narrative of their experience identifies problems, priorities, impact on daily life
• Ask if symptomatic drugs are effective (NICE Cg56)
• Define overall goals & priority for the review
• Review the research evidence e.g. STOPP START, use treatment database (NICE CG56)
• Apply clinical judgement and personalise therapy (NICE CG56)
Agree actions to stop, reduce dose continue or start

EDUCATE, EMPOWER, ENABLE

• **Purpose of this is to agree actions with the patient (Care Plan) and the prescriber.**

• Negotiate /Agree a way forward with the patient

• Present options to prescriber in simple format
  – SBAR tool, ICARUS grid, letter
Components of a Care plan

Fit for Frailty 2 2014

• Named co-ordinator

• Main & Current Issues

• **Management/Maintenance Plan** – With goals and solutions, Who is responsible for carrying out? Timescales, Review

• **Escalation Plan** – What to look out for, What to do / Who to contact?

• **Urgent care Plan** - for crisis

• Overall aim is Comfort – for palliative treatment only, even in life threatening situations

• **Advanced care plan /End of Life Plan** agreed / just in case medicines
Communicate with other relevant parties as appropriate

- **Purpose**: to facilitate the implementation of care plan and ensure support from all relevant parties.
- Produce a written summary highlighting rationale, agreed action for each drug change and monitoring
- Communicate (consent)
Monitor, review and adjust regularly

ENABLE, EMPOWER

• **Purpose**: to maintain continuity of care by ensuring a robust chain of professional responsibility.
Measuring outcomes  (Fit for Frailty 2)

- Self-Reported Quality of Life (e.g. EQ5D)
- Patient and carer experience of health and social care services
- Patient safety and avoidance of harms such as falls, pressure sores, adverse drug reactions, deterioration in mobility.
- Self-reported pain (e.g. geriatric pain measure short form)
- Self-reported functional measures (e.g. Nottingham Extended Activities of Daily Living scale)
- Reduction in excess bed days/delayed transfers of care
- Reduction in number of outpatient visits
- Reduction in number of primary care consultations
- Staff experience of care and satisfaction
Collaboration and Care co-ordination

EDUCATE, EMPOWER AND ENABLE

- Agree care plan (FFF1, NICE CG56)
- Communication & Coordination
- Monitoring and follow up
  - Withdraw slowly & sequentially
- Record and share information

Relatives, geriatricians, clinical mental-health teams, specialist-clinicians, GPs, nurses, carers, pharmacists, community pharmacists, dieticians, social-care providers, patient discharge teams
Thank you for listening
Any Questions?
Poll Question Number 1

Overall I found the webinar content useful to me:

- Agree strongly
- Agree
- Disagree
- Disagree strongly
Poll Question Number 2

I would recommend this learning event to others:

• Agree strongly
• Agree
• Disagree
• Disagree strongly
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