London North West Healthcare NHS
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Medicines optimisation for older people with disabilities

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Care of older people and stroke pharmacist

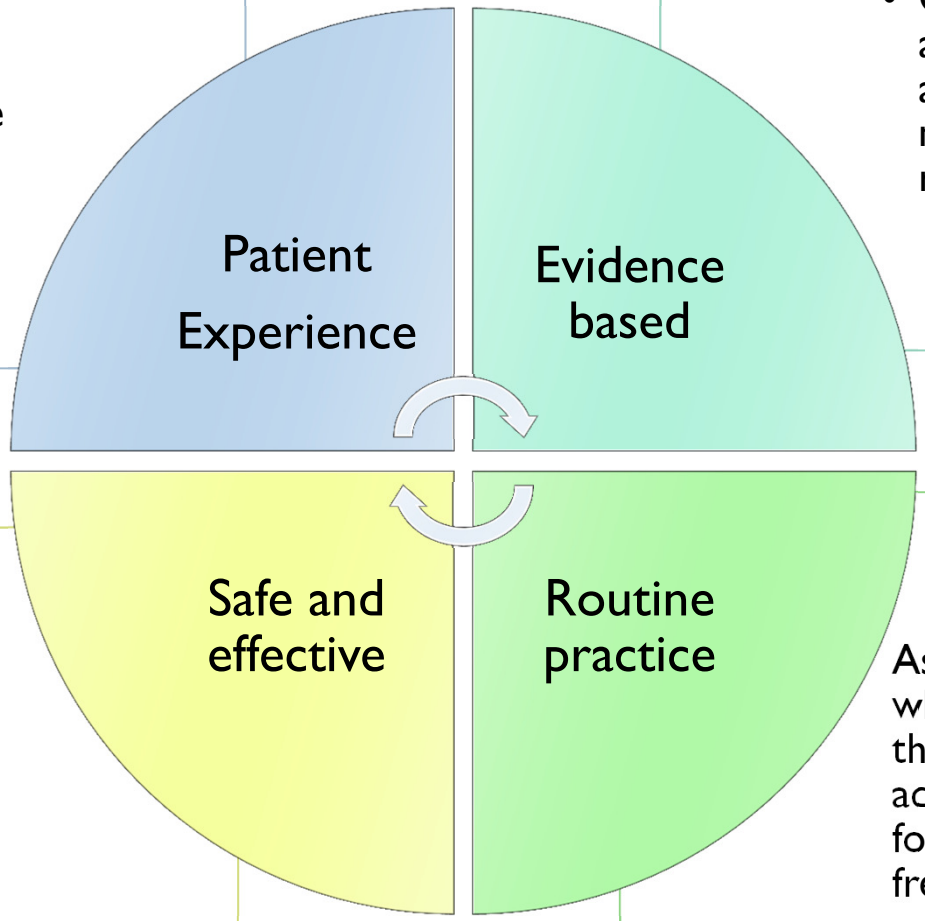
Objectives

- Medicines Optimisation
  - Examples
- Identifying patients
  - PREVENT
- Targeting patients in the hospital this includes frailty as a measure - PREVENT
  - Examples
- Frailty
  - Examples

Medicine optimisation[1]

- Address the patients needs establish if person and/or carers have any concerns or questions

- Check there is a clear and valid reason and appropriate monitoring and reviews



- Discuss individualised treatment goals

Ask patients about what simple changes they think will improve adherence such as the formulation or frequency of administration

PREVENT^2

- Tool developed at LNWH to identify high risk patients

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PREVENT TOOL: "High Risk" patient REFERRAL FORM

Tool to identify patients at risk of preventable medicines-related readmission with **unmanaged** complex pharmaceutical issues, where the risk is **modifiable** through pharmaceutical care.

Patient Name : **Hospital Number:** **DOB:** **Ward :** **Bed No:**	**Date of Referral :** **Name of Referrer :** **Bleep:** **Managed by :** **Referred by (please circle)** **Nurse:** *Ward/specialist/district/*other **Doctor:** *GP/Hospital/other* **Pharmacy team Therapy team:** *physio/OT/SLT/other* **Patient/ family/ carer/ friend**
Date of Admission: **Date of Discharge:**	**For Integrated Medicine Management Service (IMMS) use only:** Referral Accepted : Yes ☐ No ☐ _____

	Examples
Physical impairment	Patient has difficulties with swallowing, impaired dexterity, poor vision, hard of hearing or poor mobility which will impact them taking medication[1,2]
F**R**ailty	Patient is identified as frail using accepted methods [25] eg Clinical Frailty Index[26] 1 = very fit, 2 = well 3 = managing well 4 = vulnerable 5= mildly frail 6 = moderately frail 7 = severely frail 8 = very severely frail 9 = terminally ill
adh**E**rence/ issues/compliance support	Patient has not been taking their medicines e.g. various dispensing dates on medicines, no recent dispensing of medication, newly started on all medicines or cannot give names of medicines they are taking. Patient has decided to stop taking all or some of their medicines which has lead or will lead to worsening of their clinical condition[1,21]. Refer all new requests for compliance support
cogniti**V**e impairment	Patient is unable to take medication regularly without support as they have a condition which affects their memory e.g. delirium, dementia[1]
n**E**w diagnosis/exacerbation of disease/	Admission is related to poor management of medication for a long term clinical condition[13] or deterioration of organ system function eg renal, cardiac[14,21,23] Previous admission or A&E attendance within 30 days[15,16,20,22,23] Depression[17], high level of stress[18], other mental health, alcohol or drug abuse[27]
Medici**N**es related admission/ risk from specific medicines	Patient is taking a high risk medicine (e.g. anticoagulants/antiplatelets, insulin /oral hypoglycaemics, NSAIDs, benzodiazepine, antihypertensives, diuretics, beta blockers, opioids, methotrexate, injectable medicines, drugs requiring therapeutic drug monitoring esp. with no monitoring, steroids) which the patient is unable to manage.[3,4,5,6,24] Patient has a complex of medicine regimen, recent stop, start or change in medicines or Polypharmacy[7] which the patient is unable to manage[8,9,10,11,12,20]
cul**T**ural/social	Patient cannot manage daily activities independently or has carers to help with daily activities but not medicines. Patient has cultural beliefs around illness and treatment impacting medication adherence[27]. Patient has social issues such as no fixed abode, unkempt etc which impacts them taking medication[2] Smoker[19]

How are frailty and medicines issues linked?[3,4]

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.

Care of Elderly ward patients

Review polypharmacy

Optimise medicines management

Slide 5

GDPu6 Could mention some recent work done on COE, where we looked at the frailty score for each patient and then what we do for that patient.

So for patients with a score of less than < 6, check who manges the medicines, ensure each medicine has indication and is titrated to the correct dose - ensure no underdosing. If medicines havent been charted e.g. paitent has ACS but not on statin query why. Ratioanlise the medicine regimen with view to treat PMH

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Medicine optimisation in frailty

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.

Medicines review to ensure only on essential medicines relevant to patients clinical condition

Shared decision with the doctor to rationalise medicine and consideration for LCP

Slide 6

CR1 For people with a frality score >6 rationlaise medicines with a view to stop, check who is managing the medicines.
Catherine Rigby, 03/11/2016

Acute care setting – **P**hysical Impairment and F**r**ailty

Example One

79 year old Male, admitted with a fall.

Background: Hypertension, AF, Type1DM, High cholesterol
Social History: Lives alone with OD PoC and registered blind
Frailty Score: Mildly Frail (6)

Obervations:
BP: 130/60 BM: average: 6 - 8
HR: 90
U&E : unremarkable

Medicines:

- Insulin Innolet 5 units in the morning and in the evening
- Amlodipine 10mg in the morning
- Ramipril 10mg in the morning
- Bisoprolol 2.5 mg in the morning
- Atorvastatin 20mg at night
- Hypromellose eye drops 0.3% 1 drop into each eye 4x day

Patient referred as pharmacist believe the patient will not be able to manage medicines especially the insulin.

Slide 7

GDPu1 Is this examples of PREVENT referrals. Mention that in hospital we can complete an electronic referral for diabetes could the blood pressure tablets be rationalised

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Example One - continued

- Identifying how patient was managing prior to admission
  - Self managing
  - Insulin managed with listening to click on the innolet
- Referred to the Diabetic nurse specialise via an electronic referral system
  - To ensure not on appropriate dosing and falls are not a result of hypoglycaemia
- Optimising Hypertension medications
  - Ramipril - Stopped (BP stable)
  - Bisoprolol - changed to night
  - Amlodipine - in the morning

Splitting timings of antihypertensive to reduce risk of falls

Acute Care Setting – Adherence Issues

Example Two

- Mr JW referred by the ward pharmacist as refusing all medicines and brother concerned he not take medicines at home

- On assessment
  - No capacity to make financial decisions but still had capacity to refuse carers and medicines

"I am 87 years old and I want to die peacefully…I don't need medicines"

- Drs adamant to give him meds. He refused.

  - What do we do???

  - Discharged without medicines
  - readmitted due to clinical condition (no carers and worsening of clinical conditions)
  - Now waiting for placement as agreed he cant manage

- NOTE – people are allowed to make decision you don't agree with (and maybe even you think are foolish). We all are.

Acute care setting – Adherence Issues and Medicine Compliance Aids

Example Three

- **Most referrals made for medicine compliance request[5]**
- Referral often made by OTs /Pharmacists/ Family members
- Electronic Referral system on 'ICE order comms' launched in September 2016

1. Patient referred due to social issues
   a) Lives alone and carers administer medicines
2. Physical impairment
3. Monitoring adherence

Liaising with :

- Patients
- Carers (Formal/informal)
- Community Pharmacist
- GP's

Optimising medicines: Cognitive support

- Dementia
  - What is happening at home
- Delirium
  - Acute onset – no previous issues (so no carer support pre admission) – may last post admission (6 weeks) who will support?
- Capacity
  - Difference in capacity to take meds vs choose cup of tea vs make financial decision (activity and time dependent)
- Role of carers

New Diagnosis/Exacerbation of disease and Medicine related admission

Example Four

- Mrs SF 78, admitted to hospital for the 3 time due to exacerbation of asthma
- Lived alone and spoke very little English
- Carers 3 x a week

- Medicines all prescribed as per the BTS guidelines
  - Salbutamol 100mcg/dose evohaler 2 puffs qds prn
  - Seretide '250' evohaler 2 puffs BD
  - Complete 2 courses of prednisolone
  - Montelukast 10mg Daily (new started on second admission as asthma not controlled)
  - Discharged from acute ward

Example Four – continue

- Identified during the medicines reconciliation process as 'high risk' patient

- Inhaler technique assessed on admission
  - Patient not counselled appropriately on inhaler technique
  - Due to language barriers
- On discharge – counselled in the patients language
  - Provided with aerochamber with a mask
- Montelukast stopped
- GP contacted to assess patient in 3 months

Cultural and Social Issues

Example Five

- Mr S, 50 year old male admitted with stroke
- Amlodipine 10mg Daily on admission
- Intentional non-adherence

Social Issues:

- Smokes 40 – 60cigs/day
- Uses recreational drugs
- Consumes 4 – 6 units of alcohol each day
- No Fixed Abode as recently divorced
- Not registered with GP

- Patient referred due to non adherence to antihypertensive

Example Five – Continued

- Referred to the Psych Liaisons Teams
  - Management of Drugs and Alcohol
- Referred to community outreach team
- Started on Nicotine Replacement Therapy (NRT)
  - referred to local community pharmacy
- Re-registered with GP surgery

Tips to take home

Reduced morbidity and mortality in frail adults through meds optimisation can be supported through:

- Identifying who is frail – they are more at risk of meds related problems than non frail patients
- Recognising which medicines are highest risk (use validated tool e.g. STOPP/START
- Work with patient and carers to manage the most important problem from a shared (collaborative) perspective
- Implement/advise patient, carer and relevant clinical staff on potential for deprescribing and appropriate polypharmacy

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2. https://www.researchgate.net/figure/237820526_fig1_Fig-1-Clinical-Frailty-Scale-Scoring-is-based-on-clinical-judgment-Reprinted-with [Accessed October 2016]
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4. British Geriatric Society. Fit for Frailty. Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. June 2014 http://www.bgs.org.uk/campaigns/fff/fff_full.pdf [accessed October 2016]
5. N. Barnett, K. Dave, P. Parmar, D. Athwal, S. Kaher, C. Ward,Impact of an integrated medicines management service on preventable medicines-related readmission to hospital: a descriptive study. September 2016. [Accessed October 2016]

Optimising medicines: Physical support

- Dexterity
  - Pill mates, Non CRC bottles , Haler-aids

- Sight impairment
  - What is the degree of impairment
  - Patients own glasses, magnifying glass
  - Braille on the box…

- Hearing impairment
  - Hearing aids - are they there/working?
  - Sign language?

Slide 18

GDPu2 Can this slide be incorporated into an example and keep it practical to hospital

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