Endorsed by ROYAL PHARMACEUTICAL SOCIETY

STOPIT review

NIHR CLAHRC North West London

Screening tool for older people's inappropriate treatment 2015

STEP 1: IDENTIFYING Potentially Inappropriate Prescriptions

Date of form	**Completed by**	**Hospital Number**	**Age**	Patient uses a My Medication Passport ○ Requested or given MMP this time ○ See notes below & tick all that apply:
Date of adm. **__/__/____** **Reliable DHx? [ ]**	**Consultant**	○ Polypharmacy (6 or more meds on adm)		**Include** all regular prescription medicines, eye drops, "prn"s except topicals, OTC items except herbal, topical or food supplements/vitamins
Is the patient on any of these prescribed medicines on admission? Rationale for inclusion: There is evidence that these medicines are more commonly problematic in the elderly and may contribute to harm (see overleaf for list of medicines)		○ Anticholinergics eg Tolterodine ○ Drugs with ACB s/e (see ACB list over)		Can cause confusion, agitation, urinary retention, constipation, glaucoma, falls
		○ ACE Inhibitors, ARBs, CCBs ○ Alpha blockers eg Tamsulosin ○ Vasodilators in HF eg Isosorbide MN		With postural hypotension (risk of syncope, falls); also↑K^+ (ACEI, ARBs), HF (Diltiazem, Verapamil) constipation (Verapamil)
		○ Centrally acting antihypertensives		Less well tolerated by older people →confusion
		○ Antihistamines, older sedating		Can cause confusion, other ACB s/e
		○ Antidepressants		Can cause ↓Na^+ (esp SSRIs), ACB s/e (esp TCAs)
		○ Anticoagulants (concomitant with): ○ Antiplatelets inc Aspirin (>160mg○) ○ NSAIDs (if >3months tick○)		↑risk if in combination with other meds known to interact/cause bleeding disorder or if Hx of PUD; monitor GFR (NOACs, NSAIDs)
		○ Antipsychotics		Can cause confusion, falls. Some also ACB&EP s/e
		○ Benzodiazepines ○ Z-drugs		Sedative. Can cause impaired balance, confusion, falls. (Withdraw benzos gradually if >4/52)
		○ Diuretics		Can cause electrolyte disturbances
		○ Opioids		Can cause constipation, also ACB s/e.
		○ Proton-pump Inhibitor >8weeks/no ind		Tick here if PPI is for gastroprotection○
Does the patient have any of these as a 'Problem' or presenting complaint on admission?: Rationale: These symptoms/problems have been identified as medication-related or the result of potentially inappropriate prescribing in elderly. Number of PIPs identified [ ] Two or more ticks in the middle column: recommend Step 2 [ ]		○ Falls		Consider review of all anticholinergics, sedatives, antipsychotics, vasodilators
		○ Bleeding		Consider I/As, combinations with antiplatelets anticoagulants, bisphosphonates, NSAIDs, SSRIs
		○ Confusion		Consider review of all anticholinergics and psychoactive drugs, sedatives
		○ Metabolic/electrolyte imbalance		Consider diuretics, ACE Inhibitors, anti-depressants, ARBs, Metformin
		○ Constipation		Opioids, oral iron, Verapamil, ACB, Aluminium antacids. Tick if on laxative○

STEP 2: MEDICINES REVIEW and DEPRESCRIBING

Date of Review **Time taken [mins]**	Review No.	**Where review took place** (Ward)	Action from STEP 1: Comprehensive review [ ] Interim only (acute) [ ] / No review [ ] Reason……
○ **Held** medicines [Number ……] list:		○ **Deprescribed** (stopped) [……] list:	Following review, were changes made? Y/N/na If **NO** please give reason, if **YES** note **number** changed in the appropriate box on the left. List medicines affected direct onto **Pharm Care Notes** or note here update later [ ] **Interim (Acute**)- action = HELD/temp change **Comprehensive** = all meds with patient - action = DEPRESCRIBED/permanent change (formulation, dose reduction or increase, switch to more appropriate) NB: Pharmacist acute review can be part of MRec Deprescribing is the role of prescribers (including NMP) Please note approx how long review took
○ **Change** dose decrease [……] detail: ○ **Change** other [……] list: ○ **No change** reason: ……		**Review led by:** Consultant via MDT ○…… Medic no MDT ○…… Pharmacist via MDT ○…… Pharmacist no MDT ○…… Other ○……	
Has review been documented on the discharge summary?			Yes/No/na
Was the patient [ ] or carer [ ] involved in the medication review			Yes/No/na Please tick either patient or carer as appropriate
Was the patient [ ] or carer [ ] counselled re changes/ new meds			Yes/No/na Please tick either patient or carer as appropriate

Generic Version 2.3 for Inpatients. Adapted from the original ImpE/STOPIT form and STOPP2 (O'Mahony et al 2014) by Chelsea and Westminster Hospital NHS FT and NIHR CLAHRC NWL 2015

STOPIT 2015 Potentially Inappropriate Prescriptions (for full list see www.clahrc-northwestlondon.NIHR.ac.uk)

ACB: Anti**C**holineric **B**urden: ◦ bladder antimuscarinics all e.g Oxybutinin, Tolterodine ◦ bronchodilator antimuscarinics all eg Ipratropium, Tiotropium ◦ intestinal antimuscarinics: Hyoscine, Dicycloverine ◦ antidepressants: Paroxetine & all tricyclics (e.g Amitriptyline) ◦ antihistamines,1st generation (sedating) e.g Chlorphenamine ◦ antipsychotics: Clozapine & all phenothiazines (e.g Promazine) ◦ opioids: all e.g Tramadol, Morphine	concomitant use of two or more drugs with anticholinergic properties (risk of increased anticholinergic toxicity: confusion, agitation, acute glaucoma, urinary retention, constipation); with delirium or dementia (risk of exacerbation of cognitive impairment, increased confusion, agitation); to treat extra-pyramidal side-effects of antipsychotic/neuroleptic drugs; with narrow-angle glaucoma (risk of acute exacerbation); with chronic prostatism/bladder outflow obstruction (may cause urinary retention)
ACE inhibitors e.g. Enalapril **Angiotensin Receptor Blockers** (ARBs) e.g. Losartan	with persistent postural hypotension or hyperkalaemia or with Aldosterone antagonists without regular K+ monitoring (6 monthly)
Alpha blockers e.g. Alfuzosin, Doxazosin, Tamsulosin	with symptomatic postural hypotension or micturition syncope
Amiodarone	as 1st-line in SVTs (higher risk of s/e than other antiarrhythmic s)
Anticholinergic/antimuscarinics e.g. Hyoscine	(also many meds with a/cholinergic side-effects)- see ACB above
Anticoagulants, oral (includes vitamin K antagonists, newer oral anticoagulants (NOACs) direct thrombin inhibitors (e.g Dabigatran) and factor Xa inhibitors (eg Apixaban, Rivaroxaban). See also antiplatelets	with other meds that increase bleeding risk/GI bleed (antiplatelets, bisphosphonates, NSAIDs, SSRIs/any linked with bleeding disorders); for > 6 months for first DVT or > 12 m for first PE without continuing provoking risk factors (e.g. thrombophilia) (no added benefit) NOACs: caution if poor kidney functn (Avoid Dabigatran if eGFR <30)
Antidepressants (see also SSRIs and Tricyclics)	with hyponatraemia (Na+ < 130 mmol/l)
Antihistamines, 1st-generation e.g. Chlorphenamine	Sedating, see also **ACB**: safer, less toxic choices widely available
Antiplatelet agents e.g Aspirin, Clopidogrel	with oral anticoagulants in stable disease/AF (no added benefit); Aspirin: long term >160mg/d or with Clopidogrel unless stent, concurrent ACS, carotid arterial stenosis (no evidence for ↑benefit)
Antipsychotics/neuroleptics (particularly phenothiazines e.g. Promazine) see also **ACB**	other than Quetiapine/Clozapine in PD or Lewy Body disease; as hypnotics (risk of confusion, EPS); in dementia (risk of stroke)
Benzodiazepines e.g. Diazepam	for ≥ 4 weeks (no indication for longer treatment) withdraw gradually with respiratory failure (risk of exacerbation); (**Z-Drugs** too: may cause protracted daytime sedation, ataxia**)**
Beta-blockers e.g. Atenolol	in combination with Verapamil or Diltiazem (risk of heart block)**;** with frequent hypoglycaemia in diabetics (risk of masking)**;** with bradycardia (< 50/min) or heart block (risk of asystole)
Bisphosphonates, oral (e.g. Alendronate)	with history of upper GI disease or bleed or PUD
Digoxin	for heart failure if normal systolic ventricular functn (no benefit)
Diuretics, Loop (e.g. Furosemide, Bumetanide); **Thiazide (**e.g. Bendroflumethiazide)	Loops as 1st line for hypertension (safer, more effective alternatives); for ankle oedema (if no evidence of HF other indication) Thiazides with current serum K^+ < 3.0 or Na^+ < 130 or hypercalcaemia
Donepezil and other acetylcholinesterase inhibitors	with bradycardia, heart block or recurrent unexplained syncope
Ferrous salts oral doses> elemental **iron** 200 mg/day	(no further amount absorbed) Constipating
Isosorbide Mononitrate (and all other vasodilators in HF)	with persistent postural hypotension (risk of syncope and falls)
Methyldopa (all centrally-acting antihypertensives)	unless clear intolerance of 1st line (less well tolerated by elderly)
NSAIDs (e.g. Diclofenac, Ibuprofen)	if eGFR<50mL/min (risk of AKF); or for >3 months (safer alternatives) with anticoagulants (risk of GI bleed), antiplatelet, corticosteroid but no PPI cover (risk of PUD); with severe hypertension/HF or if concurrent cardiovascular disease (risk of MI and stroke)
Proton Pump inhibitors (PPIs) e.g. Omeprazole	for > 8/52 in uncomplicated PUD/oesophagitis at therapeutic dose (NB: indicated for Aspirin cover if history of PUD)
Selective Serotonin Re-uptake Inhibitors (SSRIs) e.g. Citalopram, Paroxetine. See also antidepressants	with current or recent significant hyponatraemia or bleeding disorder with glaucoma, prolonged QT interval (Citalopram, Escitalopram) confusion, extra-pyramidal effects (Paroxetine, see also **ACB**)
Tricyclic Antidepressants (e.g. Amitriptyline) See also **ACB**	with current or recent significant hyponatraemia, dementia, narrow angle glaucoma, cardiac conduction abnormalities
Vasodilator drugs including: **Hydralazine, Nitrates**	with persistent postural hypotension (risk of syncope and falls)
Verapamil	with NYHA Class III/IV heart failure or with chronic constipation