CURRENT THINKING ON... HOME MEDICINES REVIEWS FOR VULNERABLE OLDER PEOPLE

Welcome to our CPD module series for community pharmacy technicians. Written in conjunction with the ***Pharmacy Magazine*** CPD series, it will mirror the magazine's programme throughout the year. The series has been designed for you to use as part of your continuing professional development. Reflection exercises have been included to help start you off in the CPD learning cycle.

Contributing author: Lelly Oboh, consultant pharmacist in care of older people.

Older people living with frailty are the fastest growing sub-group of our ageing population. This module looks at medicines use reviews (MURs) undertaken with the patient in his/her own home, including warden assisted or sheltered accommodation. This group of patients are the most vulnerable to adverse drug events (ADEs) and will benefit from domiciliary MURs for a number of reasons.

Many are housebound, have difficulties accessing face-to-face pharmaceutical care and rely on others for medicines support, which can result in poor engagement with both the prescribers and dispensers.

Multi-disciplinary team involvement, frequent hospital visits and care delivery via complex health and social care pathways are normal for this group – and that increases the risks of ADEs due to communication breakdown and poor transfer of information. Poor patient engagement and poor communication between various practitioners prescribing, dispensing or administering medicines can lead to errors, ADEs and non-adherence, especially during transfer of care or handover points.

Domiciliary MURs provide an opportunity to understand what is happening with the patient and their medicines, monitor medicines use, and detect and resolve any ADEs.

Frailty

Frailty is a progressive, long-term condition with episodic deteriorations. In frail older people, a minor event can trigger major changes in health status from which they may fail to return to their previous level of health. Some 25 to 50 per cent of people aged over 85 years are frail.

Frail people are at higher risk of hospital admissions, stay longer in hospital and are higher users of health and social care resources. They typically present with falls, immobility, incontinence, delirium and ADEs – sometimes referred to as the 'geriatric giants' or 'frailty syndromes'.

An older person who is taking five to nine or 10 or more drugs is one-and-a-half and three times more likely to be frail compared to those on fewer than five drugs.

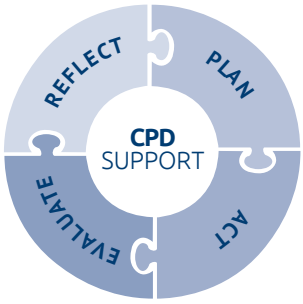
Frailty poses a challenge to medicines optimisation as it can affect how patients access, adhere to and respond to medicines. Housebound patients, for example, may have reduced muscle strength or poor dexterity, meaning they require help to collect and/or administer medicines. Similarly, cognitive impairment may result in forgetting to take medicines or difficulty mastering and continuing techniques needed for self-administration (e.g. inhalers, blood glucose monitoring devices). Sensory impairments and swallowing difficulties may also be practical barriers to adherence.

MODULE NUMBER: 78

AIM: To help you understand how a home medicines review can benefit older people.

OBJECTIVES: After reading this module, pharmacy technicians will:

- **Be able to describe the different factors that impact on medicines optimisation**
- **Recognise that being housebound can result in poor engagement with prescribers and dispensers**
- **Appreciate that polypharmacy increases non-adherence and is the biggest risk for adverse drug events.**



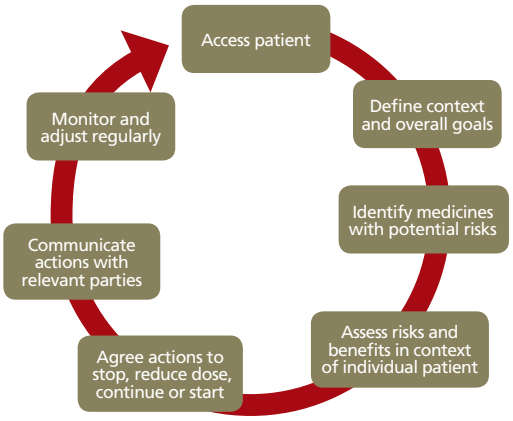
Polypharmacy

Polypharmacy increases non-adherence and is the biggest risk factor for ADEs – it is implicated in up to 17 per cent of hospital admissions. In addition, polypharmacy and multi-morbidity increase drug-drug/disease interactions. Contributing factors include:

- Multiple long-term conditions
- Increasing age
- Therapeutic advancements and increased accessibility to medicines
- Prescribing cascade (where the adverse effect of a drug is mistaken for a new symptom and a second drug is inappropriately prescribed)
- Performance targets driven by clinical guidance
- Multiple prescribers
- Reluctance to stop medicines and poor evidence for withdrawal
- A "pill for every ill" and psychosocial issues
- Patient or carer demand
- Poor patient engagement and communication.

Non-adherence to medicines in older people is multifactorial and both

Figure 1: A patient centred approach to managing polypharmacy in practice



intentional and unintentional non-adherence often co-exist in the same individual. For example, an older person may be 100 per cent adherent with their analgesics, unable to manipulate their inhalers, forget to take their antibiotics and be unwilling to take a diuretic for fear of side effects. It is important therefore to identify the reasons behind the non-adherence and to give the appropriate information and support to meet the specific needs identified.

ADEs are more common in older people and are implicated in 16.6 per cent of hospital admissions. Most are dose-related, predictable and preventable. Polypharmacy also means the risk of a drug error post-discharge is up 70 per cent as a result of poor transfer of information and frequent drug changes.

Many ADEs in older people remain undiagnosed because they are atypical, vague and non-specific (e.g. confusion, unsteadiness, constipation, falls). Asking open questions during patient consultations is essential when identifying and resolving any ADEs.

An ADE should be suspected when an older person presents with new symptoms. Common ADEs include gastrointestinal and haematological reactions, falls, delirium and anticholinergic symptoms.

Frail patients living in domiciliary settings may face additional challenges with medicines optimisation compared to robust or fit older people, such as:

- Over-reliance on telephone consultations and third parties to speak on their behalf
- A home environment with inadequate facilities for medicines storage and keeping medicines within easy reach
- Poor or delayed access to medicines supply leading to stockpiling and wastage
- Considerable involvement of non-clinical staff (e.g. relatives, friends, carers and care workers) with managing complex medicines issues
- Aligning carer visits with administration time for critical and PRN or 'as needed' medicines
- Complex issues with capacity and consent
- Safeguarding and unintentional overdose.

Managing the problem

Medicines use review is the broad term used to describe interventions to review a patient's medicines with the aim of rationalising and improving the quality, safety and appropriate use of medicines. In frail older patients with polypharmacy, it also considers whether any 'deprescribing' – the safe and effective cessation (withdrawal) of inappropriate medicines – should take place.

A step-by-step approach to optimising medicines use in older people was proposed by Barnett et al. (see Figure 1). Each step provides practical support for embedding medicines optimisation into everyday practice. It suggests points to consider, actions to take and questions to ask, allowing issues to be prioritised based on the importance to the patient, associated risks, benefits and current evidence.

Case study

Josephine Summers is 79 years old and lives alone in a third floor warden-assisted flat. Recently, she has started to show signs of frailty and dementia, including slower mobility, two falls and cognitive impairment

Josephine has a past medical history of hypertension, postural hypotension, anxiety and type 2 diabetes. In spite of these, she visits the local shops daily and regularly attends activity classes. She is out for most of the day, returning home late in the evening.

Her medicines are dispensed in a monitored dosage system (MDS), which she picks up every Thursday morning from your pharmacy. She had been self-administering her medicines until a few weeks ago when she was referred by her GP to the district nursing team due to high Hb1Ac as well as fluctuating hypo- and hyperglycaemia. Her insulin has since been changed from Humulin I bd to Lanctus od and the district nurses have been visiting every morning to support her with the changeover.

Prior to a domiciliary medicines use review (MUR), the district nurse reports that Josephine has not quite mastered the administration technique with her Lanctus and her blood sugar levels are still fluctuating. The nurse is also concerned that she is not taking her oral medicines as prescribed, although Josephine maintains that she is. As a result, the nurse has insisted that Josephine waits for their morning visit so she can be supervised while taking her medicines. Josephine dislikes this arrangement as she finds it limits her activities and lifestyle. The nurse then puts the evening and night-time medicines out onto a saucer for her to take later. The nurse says that sometimes the medicines are still there the next morning.

During the domiciliary MUR, Josephine said that she wants to be left alone to manage her medicines and get her blood sugar levels back to normal. Initially, she played down forgetting to take her medicines but later admitted that she stopped taking her water tablets (furosemide) a long time ago because of urine frequency and was not keen on taking the evening and night-time medicines. She said she felt overwhelmed taking so many medicines and was keen to know why and how long she has to take them for.

- Consider this case study. What steps could be taken to tackle the issues raised?

reflective exercises

- **Use your PMR to identify two patients who are over 80 years of age and take eight or more medicines**
- **List any drug, patient, health, functional or psychosocial factors that may increase their risk of ADEs**
- **Can you identify any potential prescribing cascades from the medicines list?**
- **Think about your last face-to-face consultation with a patient about their medicine(s).**
- **For what percentage of the conversation were you giving information, advising or telling?**
- **Did you find out how they felt about taking the medicine(s)?**
- **What three questions might you ask next time to get this information?**

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Next month: we focus on bipolar disorder.