Family Nursing & Home Care

Deprescribing Guidelines

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Version Control

Date	Version	Summary of changes made
2024	1	New guideline

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Introduction

This guidance has been adopted and amended with permission from Health and Community Services (HCS) for use within Family Nursing & Home Care (FNHC), to guide all independent non – medical prescribers (NMP) in the practice of deprescribing.

Deprescribing is synergistic with inappropriate polypharmacy. It is the process of tapering, withdrawing, discontinuing or stopping medicines to reduce potentially problematic polypharmacy, adverse drug effects and inappropriate or ineffective medicine use. It should be undertaken in the context of reviews for appropriate polypharmacy in partnership with the patient (and sometimes their carer) and supervised by a healthcare professional.

Aim of Deprescribing

The aim of deprescribing is to:

- improve quality of life
- avoid worsening of disease or causing withdrawal effects
- be effective in reducing pill burden
- maintain control of chronic conditions

Scope

This guidance applies to any independent non-medical prescriber administering care and where deprescribing is within their scope of practice, for any patient receiving care within FNHC.

People at Increased Risk of Medicine Related Problems (list not exhaustive):

- Multi-morbidity
- Polypharmacy
- Older adults
- Patients with frailty
- Women
- Residents in care home
- Learning difficulties
- Sensory impairment e.g. sight or hearing
- Physical problems e.g. arthritis, swallowing difficulties
- Mental states such as confusion, depression, anxiety, serious mental illness
- Communication difficulties
- Patients with indications of shortened life expectancy/ end of life
- Impairment/ decline in hepatic/ renal function
- Acute illness
- Recently discharged from hospital / transferred to care home

Approach to Stopping a Medicine

A five step process can be used when stopping medicines; this should be initially as a trial:

1. Gain a comprehensive medication history and check adherence, if a medicine is rarely or never taken this makes stopping easy (e.g. patient states in the consultation they are not taking a particular medicine or if the medicine is administered the patient may continually spit out doses without swallowing).
2. Identify any potentially inappropriate medicines (PIM).
3. Determine whether the PIM can be stopped.
4. Plan the withdrawal regimen: reduce or stop one medicine at a time, if problems develop it makes it easier to identify the likely cause. Consider if the medicine can be stopped abruptly, e.g. if toxicity has developed, or needs to be tapered, this is usually the best option; sometimes a smaller dose may need to be continued long term.
5. Check for benefit or harm after each medicine has been reduced or stopped (provide contact details to the patient for support in case of problems), this may include monitoring tests.

However, there are different approaches to stopping medicines that may be employed:

- **Stepwise' approach.** Useful if the patient is well and clinically stable but there is a risk that multiple changes in drugs will destabilise their situation. Tapering the dose helps reduce the likelihood of an adverse withdrawal event for some medicines.

- **All at once.** Useful if the patient is unwell as a result of likely drug side effects or in a safe monitored environment (e.g. admission to hospital).

- **Mixed approach**. In practice, often several drugs can be stopped or reduced at once with little chance of harm. However, certain drugs (e.g. antidepressant and antipsychotic drugs) will need to be withdrawn more cautiously. In these situations it should be documented clearly which drugs can be stopped immediately and which drugs are to be withdrawn more cautiously.

A similar but more comprehensive approach can be found at: Deprescribing - UpToDate

Possible Barriers

Deprescribing must be done judiciously, with monitoring, to avoid worsening of disease or causing an adverse drug withdrawl reaction (ADWR). These typically occur when a medication is discontinued too quickly and without tapering. A number of drug classes have been associated with ADWRs, for example, beta-blockers, corticosteroids and benzodiazepines.
https://www.uptodate.com/contents/image?imageKey=PC%2F126485&topicKey=PC%2F122694&source=see_link

This needs careful discussion on an individual basis to gain patient understanding and acceptance. It may be helpful to use different terminology for patients. Treatment and care should take into account individual needs and preferences. People who use health and social care services should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals and social care practitioners. It is recognised this is a complex process, not a single act, involving multiple steps.

End of Life

The palliative approach should be considered the last phase for patients with multi-morbidity in whom multiple active treatments are no longer appropriate. Consider the surprise question:
"Would you be surprised if this person died in the next year?"

If 'No', then for any new medicine, additional considerations are needed. It may not be appropriate to start some medicines or to continue others. Open and transparent discussions must be had with patient, relatives and carers and the following questions should be considered where appropriate:

- Who is taking responsibility for the medicines?
- What are the medicines achieving?

The harm to benefit profile should be considered.

Risk vs Benefits of Medication

When deprescribing it is important to discuss benefit to harm profile with the patient using patient decision aids. The 'number needed to treat (NNT)' is a measure of how effective a particular medication is. The NNT is the average number of patients who are needed to be treated for one benefit to be realised compared with a control in a clinical trial (defined as the inverse of relative risk reduction). So if treatment with a medicine for one year reduces the death rate over five years from 5% to 1%, the absolute risk reduction would be 4% (5 minus1) and the NNT would be 100/4 = 25. That means the number needed to treat with that medicine for one year to prevent one death is 25. The ideal NNT is 1, where everyone improves with treatment. The higher the NNT, the less effective the treatment.

The NICE database of treatment effects (NG56) is a useful interactive resource for prescribers to make decisions regarding which treatments are of benefit to the patient. This tool is designed to inform discussions between patient and clinician when considering the benefits and harms of taking long term medication as it shows basic data from clinical trials covering annualised absolute effect and numbers needed to treat. https://www.nice.org.uk/guidance/ng56/resources

Approach to Reviewing Medicines

A number of screening tools are in use for carrying out medication reviews. Clinicians should use the tool they find the easiest to use to support the medication review process. The care should then be tailored to each individual patient's needs. Examples of tools and resources for use:

IMPACT tool: Improving Medicines and Polypharmacy Appropriateness Clinical Tool Our resources | PrescQIPP C.I.C

STOP/START tool: identifies high risk problems in prescribing for older people, both in terms of reducing medicine burden and adding in potentially beneficial therapy.

NO TEARS: Need and indication, Open questions, Tests and monitoring, Evidence and guidelines, Adverse events, Risk reduction or prevention, Simplification and switches.

7-steps approach: Polypharmacy guidance centres around the individual patient. Polypharmacy guidance | Right Decisions (scot.nhs.uk)

Beers Criteria: Medicines that can cause increased adverse events in older people because of altered pharmacokinetics, co-morbidities or physiological changes associated with aging. Medichec

Using tools to support medication review – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

MedicinesComplete — Interactions Checker Stockley's Interactions Checker

Additional Considerations

Disease

- Are the symptoms caused by a disease or due to a medicine already being taken?
- Consider the time to benefit, have you asked yourself the 'surprise question'? Is the patient moving towards end of life?
- Has physiology changed significantly? Will this affect the pharmacokinetics of the medicine

Medicine

- Is there a documented indication for the medicine
- Is the medicine effective for the condition
- Is there sufficient evidence
- Does the medicine produce limited benefits for the indication
- Are there any clinically significant drug interactions
- Have these been explained to the patient
- Is there unnecessary duplication with other medicines
- Is the likely duration of therapy known and acceptable
- Is the use of the medicine consistent with current guidelines
- Does the dose need to be up/ down titrated? If so by who and how? Is the patient aware?

Patient

- Is the patient taking the medication as it is prescribed? If not, explore reasons for this

- What are the patients priorities/ values/ expectations
- What are the likely adverse effects, does the patient know
- Is the dose and frequency correct for the individual
- Is the frequency practical for the patient
- Do they feel they have an acceptable medication burden
- Where required, can appropriate monitoring be achieved/ appropriate timeframe
- Plan to follow up and evaluate response to deprescribing, within appropriate timeframe
- Safety net advice

Cost

Is the medicine the least expensive compared with others of equal effectiveness?

Shared Decision Making

Patients have a right to be involved in discussions and make informed decisions about their care. The person's needs and preferences must be considered. The treatment, care and if appropriate the deprescribing process should all be explained in a way the person understands.

Patient decision aids (PDA's) are of value for the shared decision making process. These are appropriate when more than one course of action is possible and where the best decision depends on the patient's reaction to the outcome probabilities. Short versions that can be used in a consultation include PDAs developed by NICE as part of a clinical guideline intended to help a person making a decision weigh up the possible advantages and disadvantages of the different treatment options (which may include no treatment).

Have you had an open discussion about the advantages and disadvantages of the medicine

Have you considered using a patient decision aid or tool to support and help the patient understand the NNT, number needed to harm (NNH) and probability of the risk and benefits of the proposed treatment

Does the patient need more time to consider the options fully? Do they need to discuss with their family or do they need more information? Is another consultation needed

Shared decision making | NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE

A Competency Framework for all Prescribers | RPS (rpharms.com)

Duty of Care

Breach of duty - A healthcare professional is open to a claim of clinical negligence if their actions fall below the reasonable standard of their peers. To succeed in a claim of clinical negligence, a claimant must establish all of the following elements:

A duty of care – A healthcare professional has a clear duty of care to patients under their care.

AND

Breach of duty – It must be shown that the claimant did not receive the appropriate standard of reasonable care. This is established where it can be shown that no other reasonable practitioner of like expertise, skill and experience, faced with the same set of circumstances would have acted.

AND

Harm was caused

AND

Causation arises where it can be shown that but for the negligence act or omission, the outcome would have been different i.e. the breach in duty caused the adverse outcome which arose. This link can be difficult to prove.

Consent

Consent of the individual must be sought and where applicable then a mental capacity assessment completed if appropriate. To be valid, consent requires three essential components – it must be **free, full and informed** - i.e. a patient must have capacity to make the decision in full knowledge of all relevant information and must do so voluntarily. Enough time is needed to discuss care. This may result in longer or alternative forms of consultation, and regular, planned reviews may be of benefit. As deprescribing becomes accepted practice, practitioners who fail to consider deprescribing and advise patients of the potential benefits and options may expose themselves to clinical negligence claims. Patient consent to stop, start, change or reduce a medicine must be based on full disclosure of all material risks to that patient. 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.

Clinical Documentation

Good clinical documentation is essential when deprescribing. There should be a clear record of the logical reasons behind the changes being made, particularly where the care decision does not match what the best available evidence seems to suggest.

Key Points

- Discuss deprescribing before initiating any new medicines for a trial period.
- It is essential to deprescribe, reduce or substitute inappropriate medicines.
- Deprescribing should be planned, one medicine at a time, offered as a trial, the dose gradually tapered (where indicated) and any returning symptoms monitored.
- Deprescribing should incorporate a process of shared decision making, as a partnership between the patient and the prescriber
- Regular patient review, with support from a healthcare professional is required for successful deprescribing.
- It is sometimes better not to start a medicine than to tackle deprescribing in the future, particularly in certain therapeutic areas.
- Older people, those who are end of life and those with increasing frailty are frequently prescribed unnecessary or higher risk medicines and should have more frequent medication reviews.

Deprescribing Algorithms

https://www.prescqipp.info/media/1575/attachment-1-general-deprescribing-algorithm-20.pdf

https://www.prescqipp.info/media/1581/b176-polypharmacy-practical-guide-to-deprescribing-briefing-20.pdf

Bulletin 267: PPIs - Long term safety and gastroprotection (prescqipp.info)

https://www.prescqipp.info/media/1576/attachment-3-noac-and-lmwh-deprescribing-algorithm-20.pdf

https://www.prescqipp.info/login/?returnurl=%2fmedia%2f3995%2fdeprescribing-algorithm-bisphosphonates-for-osteoporosis-20.docx

https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/04/Polypharmacy-Guidance-2018.pdf

https://deprescribing.org/resources/deprescribing-guidelines-algorithms