OCTOBER 2016

MEDISYSTEM NEWSLETTER

MediSystem™ Pharmacy
A SHOPPERS DRUG MART® COMPANY

DEPRESCRIBING RESIDENT-CENTERED CARE

WHAT IS DEPRESCRIBING?

Deprescribing is the planned, supervised cessation or dose reduction of drugs that may no longer be beneficial or may be causing harm.

As people age, goals of drug treatment can shift from reducing risk and prolonging life to maintaining quality of life and maximizing comfort. Drugs that were once deemed necessary and helpful may no longer be helping residents and families achieve their goals of care. Sometimes, these drugs may even cause more harm than good. In these cases, it may be appropriate to stop certain medications or reduce their doses.

WHY DEPRESCRIBE?

Older people often end up taking many medications. In Ontario, over two-thirds of seniors are on five or more medications. Guidelines provide instruction on how to add medications and only apply to a single medical condition. Many older adults have multiple medical conditions and specialists and therefore end up on several medications. As people age, medications that were once effective and safe may no longer be so. Frail elderly are more prone to adverse effects and certain drugs should therefore be avoided in older persons ("potentially inappropriate medications"). Use of inappropriate medications is associated with increased risk of many adverse health outcomes such as falls and hospitalizations.

RESIDENT VALUES, PREFERENCES AND GOALS

A critical step in the deprescribing process is discussing resident/family values, preferences and goals of care. By doing this, we foster shared decision making and help residents/families achieve their individual goals. Ask residents/families what their goals are; which symptoms or problems are most concerning to them. There is often a trade-off between benefits and harms of medications as life expectancy decreases. Each resident or family may have different values and preferences, so it is important not to assume that they will all have the same goals.

END OF LIFE

It is important to discuss goals in all cases, but particularly as residents near end of life. Towards end of life, many residents and families may value a reduced burden of treatment. Deprescribing is therefore an important part of caring for these residents. Prognosis and life expectancy are difficult to predict. Tools exist to assist clinicians in predicting life expectancy and can be useful in guiding discussions. Other factors may also be triggers for discussing goals of care and deprescribing: frequent hospitalizations, significant decline in functional status, or presence of terminal conditions (eg. advanced dementia). Clinicians should respect that some residents and caregivers may not wish to discuss the trade off between quality of life and life expectancy.

WHERE TO START

Careful medication review will help identify which medications may be suitable for deprescribing. Thorough assessment of the resident (eg. lab assessment, vitals, pain scale scores) and their medical/medication history are a critical part of this.

FOR EACH MEDICATION, THINK ABOUT THE FOLLOWING POINTS:

QUESTIONS	RATIONALE	EXAMPLE OF DEPRESCRIBING SITUATIONS*
Is this medication being used to prevent a future disease, to manage a troubling symptom or improve quality of life?	Use of medications to prevent a future disease or to prolong life may not be compatible with goals of care as residents near end of life – these medications may therefore be unnecessary and increase treatment burden. Medications that manage acute symptoms such as pain and anxiety are often necessary and indicated. Consider tradeoffs in preventing future disease versus minimizing treatment burden and maximizing quality of life.	Advanced dementia resident who is immobile and requires total care is taking a bisphosphonate (eg. Actonel®), calcium and vitamin D. Statin (eg. Lipitor®) in a palliative resident whose goals of care are comfort only.
Is this medication helping?	Evaluate whether a medication is effective in managing a symptom or problem and achieving goals of care. Is there evidence supporting efficacy of a drug? If not, deprescribing should be considered. If a medication is not helping to manage a symptom or problem, deprescribing should be considered. Consider tradeoffs of benefit verses harm – it can be helpful to provide ballpark estimates of treatment efficacy and harm (eg. using number need to treat or absolute risk).	Gabapentin started four months ago to treat neuropathy which has not improved pain. Docusate to manage chronic constipation.
Is this medication causing harm? Does the harm outweigh the benefits?	Evaluate whether the medication is causing any adverse effects; whether these adverse effects outweigh potential benefit or are especially troubling for residents and families.	Metoprolol for hypertension in a resident complaining of dizziness with frequent falls. Trazodone for insomnia causing morning somnolence and dry mouth. Gliclazide to treat type 2 diabetes is causing frequent hypoglycemia in a resident whose A1C is 6.5%.
Is the time to benefit (TTB) greater than the resident's life expectancy?	Some preventive medications take time to become significantly effective – this may be longer than the resident's life expectancy making it unlikely that they will benefit.	Metformin (TTB ~ 10 years) initiated 6 months ago in a resident with moderate-severe dementia and no symptomatic hyperglycemia.
Is this symptom caused by a drug?	A prescribing cascade occurs when a medication is used to treat the side effect of another medication. This can cause the number of medications a resident is taking to add up. It may be better to stop the offending drug and look for an alternative.	Pregabalin started for neuropathy → *ankle edema* → furosemide → *hypokalemia* → potassium supplement.

** Example situations only. Individual decisions may vary depending on resident-specific factors as well as values, preferences and goals.*

DEVELOPING A PLAN

A deprescribing plan should be developed in collaboration with the resident/family. Does the resident have a preference as to which drug they would like to stop first? If a drug needs to be tapered, what is the preferred rate and duration? What is the best frequency of follow-up?
It is also important to remind residents and families that if symptoms return or an underlying disease worsens upon deprescribing, the drug (or an alternative) can be restarted and that the resident will be monitored closely during the process. Residents, families and caregivers should also have a clear idea of what can be expected (eg. potential withdrawal symptoms, potential benefits) during the deprescribing process. Doing these things will help enable a collaborative deprescribing process.

References available upon request.