Deprescribing Guide

The information in this document should be used as a pragmatic decision aid, in conjunction with other relevant patient specific data.

Prepared by:

Oyepero Olasehinde-williams
Care homes Pharmacist
Medicines Management department
Phone: 01702 215842
Oyepero.olasehinde-williams@nhs.net

Document	Deprescribing guide
Version	1.0
Review date	July 2020

With acknowledgement to NHS Southern Derbyshire, NHS Erewash, NHS Highland, NHS Coventry, NHS Cumbria, NHS North Derbyshire, NHS Warwickshire CCGs and PrescQIPP

References:
https://bpac.org.nz/BPJ/2010/April/docs/bpj_27_stop_guide_pages_10-23.pdf
http://gmmmg.nhs.uk/docs/guidance/NWCSU-Polypharmacy-guidance-2016.pdf

NHS Castle Point and Rochford CCG
www.castlepointandrochfordccg.nhs.uk
@CPRCCG

NHS Southend CCG
www.southendccg.nhs.uk
@SouthendCCG

CONTENTS

DEPRESCRIBING

Deprescribing is the process of intentionally stopping a medication or reducing its dose to improve the person's health or reduce the risk of adverse side effects. The process of **deprescribing** can be planned and supervised by health care professionals, and where possible with the patient and their carer.

Aims of deprescribing

- To reduce potentially problematic polypharmacy
- Improve quality of life
- Avoid worsening of disease or causing withdrawal effects
- Be effective in reducing pill burden
- Reduce risk of adverse effects

Key Points

- 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 and any returning symptoms monitored.
- Deprescribing should be performed as a partnership between the patient (and carer when not possible with 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.

Steps to stopping a medication

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, if the medicine is administered the patient may continually spit out doses without swallowing or it can be seen from prescription ordering data that the medication is rarely being taken).
2. Identify any potentially inappropriate polypharmacy (PIP).
3. Determine whether the PIP can be stopped.
4. Plan the withdrawal regimen and where possible use the stepwise approach (see types of deprescribing approaches below). It is recommended to reduce or stop one medicine at a time, so 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.

APPROACHES TO DEPRESCRIBING

- **Stepwise approach**
  Medicines are stopped one at a time. 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 approach**
  All medicines to be stopped are all discontinued at the same time. 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

DEPRESCRIBING ESSENTIALS

- **Communication/ 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. Suggested definition of deprescribing for patients would involve the words:

  "Helping you to take the right medicines for you"

  To avoid misunderstanding, suggest a "trial without" rather than just stopping medicines.

  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) – see *Useful deprescribing algorithms section on page 7*.

- **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.

- **Consent**

  Consent of the individual must be sought when possible, and where applicable 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.

- **Time**

  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

PATIENTS WHO MAY BENEFIT FROM DEPRESCRIBING

It is important to consider patient groups that are likely to be taking many medicines and are particularly vulnerable to adverse drug reactions. These include:

- Multi-morbidity patients- presence of two or more long-term health conditions
- Polypharmacy- patients taking large numbers of medicines (>10)
- Elderly (>75yr) frail patients
- Housebound patients
- Patients with indications of shortened life expectancy/ end of life
- Vulnerable patients
- Decline in hepatic function / renal function

Frailty

Adults who are frail are at particular risk of adverse drug reactions, drug to drug interactions and rapid deterioration if necessary medication is not optimised (e.g. for treatment of heart failure). Frailty assessment must be considered in people with multimorbidity.

The Gold Standards Framework defines frailty as individuals with:

- Multiple co-morbidities with significant impairment in day to day living
- Deteriorating functional score e.g. performance status
- Combination of at least three of the following symptoms:
  - Weakness
  - Slow walking speed
  - Significant weight loss
  - Exhaustion
  - Low physical activity
  - Depression

In Frail patients, deprescribing must be considered to reduce any inappropriate polypharmacy, monitoring renal function and hepatic function carefully and adjusting doses to prevent toxic accumulation of drugs.

End of Life

The palliative approach should be considered for patients in whom multiple active treatments are no longer appropriate. When deprescribing in this group of patients 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

Useful deprescribing algorithms

https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3415-attachment-2-proton-pump-inhibitor-desprescribing-algorithm

https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3416-attachment-3-noac-and-lmwh-deprescribing-algorithm

https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3417-attachment-4-bisphosphonates-for-osteoporosis-secondary-prevention-deprescribing-algorithm.

References

(1) Reeve E, Shakib S, Hendrix I, et al. Review of deprescribing processes and development of an evidence-based, patient-centred deprescribing process. Br J Clin Pharmacol 2014; 78:738-47.
(2) Thomas K et al. the Gold Standards Framework Centre in End of Life Care CIC. Prognostic Indicator Guidance (PIG) 4th edition. The Royal college of General Practitioners. October 2011.
(3) Duerden M, Avery T, Payne R et al. Polypharmacy and medicines optimisation: making it safe and sound. Kings Fund Report 2013.
(4) Shared decision making; NHS Right Care. The BMJ Group.2012.
(5) PRESQIPP resources, Modules 1-6 Polypharmacy and Deprescribing. 2017.
(6) NICE Medicines Optimisation NG5. The safe and effective use of medicines to enable the best possible outcome. https://www.nice.org.uk/guidance/ng5.
(7) Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents
(8) Kelly O, Barnett N. Deprescribing- Is the law on your side? European Journal of Hospital Pharmacy, Vol 24, Issue 1.
(9) NICE Multimorbidity: Clinical assessment and management. Database of treatment effects NG56. https://www.nice.org.uk/guidance/ng56/resources.
(10) NICE. Patient decision aid. Statins to reduce the risk of CHD and stroke: patient decision aid. 2014
(11) https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3415-attachment-2-proton-pump-inhibitor-desprescribing-algorithm
(12) https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3416-attachment-3-noac-and-lmwh-deprescribing-algorithm
https://www.prescqipp.info/resources/send/356-polypharmacy-practical-guide-to-deprescribing/3417-attachment-4-bisphosphonates-for-osteoporosis-secondary-prevention-deprescribing-algorithm
(13) http://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/clinical_guidelines_front_page/PrescQipp_IMPACT.pdf
https://www.nice.org.uk/guidance/ng56/resources

DEPRESCRIBING QUICK WINS

MEDICINE	COMMENTS	EVIDENCE/RATIONALE
QUININE	Treatment should be interrupted at intervals of 3months, to assess need for further treatment	• BNF recommends a trial discontinuation with long term use.
LAXATIVE	Not >1 laxative should be prescribed as PRN. If > 1 regular laxative, reduce/stop one at a time. Reduce stimulant laxative first, increase the dose of osmotic laxative if necessary. Restart if relapse occurs. Give advice on lifestyle measures to help bowel movement.	• **Stimulant laxatives** are licensed only for short term use. • Excessive doses of, or inadequate fluid intake with **bulk forming laxative** can cause intestinal obstruction. • Inadequate fluid intake with **Lactulose** or **Macrogols** can be dehydrating
STATINS	If for secondary prevention, do not stop. If for primary prevention individual discussion about pros and cons versus time to benefit and quality of life, should all be considered	For primary prevention after **5years** use of statin **Benefit** • No statistically significant mortality benefit • 1 in 217 avoided a nonfatal heart attack (myocardial infarction) • 1 in 313 avoided a nonfatal stroke **Harm** • 1 in21 experienced pain from muscle damage • 1 in 204 developed diabetes mellitus http://www.thennt.com/nnt/statins-persons-low-risk-cardiovascular-disease/
IRON SUPPLEMENTS	Check indication is still valid, should be continued for 3months after deficiency is corrected.	
NSAIDS (Non-Steroidal anti-inflammatory drugs)	Check there is an on-going clinical indication. Can be stopped abruptly or half dose for two to four weeks then stopped.	Consider associated risk with NSAIDS e.g. declining renal function in the elderly and adverse GI effects.

Proton Pump Inhibitors	Stopping suddenly can cause rebound acid hyper-secretion. Reduce to maintainace dose and/or consider alternate day dosing. You can step down to a H^2R antagonist (No rebound dyspepsia when stopped abruptly) if a more gradual taper is required. Ensure if for gastro protection dose of Lansoprazole is 15mg whilst Omeprazole is 20mg	Increased risk for C.diff(42%), osteoporotic fractures (29%), Hypomagnesaemia (25%) usually > 1year treatment, community acquired pneumonia (30%) within 14-30days (Safe use of proton pump inhibitors document ,All Wales Medicines Strategy Group)
Weak Opioid analgesics	Is indication for use still valid? Consider regular paracetamol as a potential alternative	Consider side effects like constipation and confusion. Consider risk of falls.
Anti-hypertensives	Blood pressure for older people is expected to be above 120/80 to prevent risk of falls and below 140/90 to prevent complications. If below 120/80 review if all anti hypertensives are necessary. If appropriate dose should be tapered at monthly intervals, over three to six months.	Consider risk of falls.
Bisphosphonates	Check if there is a valid indication? Has the treatment been taken for 5years or more? Do the known possible adverse drug reactions outweigh the possible benefits? If patient is at low risk of falls, is this still needed?	Prolonged immobility is a risk factor for low BMD
Betahistine, Prochlorperazine, Metoclopramide, Domperidone	Review indication/on-going symptom. Easy to re-start if symptoms return Can cause extrapyramidal side effects including tardive, dyskinesia. Risk is greater in the frail older adults.	**Metoclopramide** restricted to short term use (up to 5 days) due to risk of neurological adverse effects. **Domperidone** is now restricted to use in the relief of nausea and vomiting and maximum treatment duration 7 days due to risk of cardiac side effects **Betahistine;** insufficient evidence from RCTs to conclude if prevents Meniere's disease symptoms. The quality of trials suggesting it may

		help control vertigo, dizziness, or imbalance is limited

Antimuscarinics (for bladder/urinary tract symptoms)	Check if there is still a valid indication for use. Review after 3-6 months Check if incontinence pads are used, is concomitant use necessary? Consider possible adverse effects like postural hypotension, constipation and urinary retention	Oxybutynin would decrease MMSE score in patients with dementia
Benzodiazepines (including Z drugs)	Check if there is still a valid indication. With long term use, risk of adverse effects including falls, exceeds therapeutic benefit of continued use. Withdrawal should be gradual to avoid confusion, toxic psychosis and convulsion.	Convert to equivalent dose of diazepam, then tapper down every 2-4 weeks by 2-2.5mg at a time. Approximate equivalent doses for **diazepam 5 mg:** ≡ lorazepam 0.5–1 mg ≡ nitrazepam 2.5–5 mg ≡ oxazepam 15 mg ≡ temazepam 10 mg ≡ triazolam 0.25 mg ≡ zopiclone 7.5 mg ≡ zolpidem 10mg
Rubefacients **(Examples; Movelat, Algesal,Deep heat, Difflam, Balmosa, Deep freeze, Transvasin heat rub)**	Evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain.	• All patients prescribed rubefacients should have their therapy reviewed. • Discontinue the prescribing of rubefacients on FP10. • Consider recommending or prescribing an effective alternative treatment if appropriate. • If these patients still wish to use a rubefacient they should be advised that they can be purchased as self-care over-the-counter (OTC) with the support of the community pharmacist. • Do not initiate new prescriptions for rubefacients.