NHS
Shropshire
Clinical Commissioning Group

# Medication Review Guidance

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| **Version Number** | **1.0** |
| **Approving Committee** | **Shropshire CCG, Quality Committee** |
| **Approval Date** | **26/06/19** |
| **Review Date** | **June 2021** |
| **Intended Audience** | **All GP practice staff** |

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# Medication Review Guide

## Executive Summary:

A medication review is defined as "a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste". (Room for Review, 2002)[1]

The review should, ideally be with the patient, but as a minimum must be with access to the full medical notes and checks should be made to ensure:

- The medication prescribed is appropriate for the patient's needs
- The medication is effective for the patient
- The medication is a cost effective choice
- Required monitoring is up to date
- There are no significant drug interactions
- The patient is not experiencing unacceptable side effects
- The patient is compliant with their treatment. Reasons for poor compliance should be explored. A concordant approach should be taken to all prescribing decisions
- Whether the patient is taking any over-the-counter and complementary medicines
- Lifestyle and non-medicinal interventions have been utilised / considered
- Whether there is any unmet need

Medication Reviews must be adequately documented. Records should include:

- Read Code appropriate to the review:
  - Level 2: Treatment Review – a review of medicines with the patient's full notes 8B314 or 8B3S
  - Level 3 (also Type 3): Clinical Medication Review – a face to face review of medicines and condition 8B3V or 8B3x
- A summary of the findings of the review, reasons for any alterations to medicines (or decision not to alter medicines regimen if appropriate)

The following do **not** count as a full clinical medication review, but may be useful as part of the medication review process:

- Technical check of the medication list or tidying up medication records e.g. removing unrequested items from repeats or dose optimisation
- Switching to a formulary item
- "linking" medication to a "problem"
- Re-authorising the repeat list or reviewing an individual medication/disease without reviewing all medication as above. An MUR (Medicines Use Review) by community pharmacists. Disease specific reviews e.g. asthma checks (unless patient takes no other medication)

# 1.0 Introduction

Prescribing of medication is the most common form of medical intervention. At any one time approximately 70% of the UK population is taking medicines to prevent ill health.[1] 80% of people over 75 years are on long term medication and 36% take four or more medicines.[2] However studies estimate that up to 50% of medicines are not taken as prescribed and medicines are implicated in between 5-17% of hospital admissions of which up to 80% could be avoided.[3]

Good quality medication review is the foundation of good medicines management for patients ensuring patients get the most out of their medication whilst minimising risks and reducing waste.

Involving patients in decisions about their treatment (concordant approach) is the key to improving patients understanding, treatment compliance, effectiveness and safety of treatment.

# 2.0 Aim

Despite publication of national guidance in 2002[3] and updated in 2008[4] the understanding of the 'gold standard' in medication review is weak and the quality of recorded medication review varies widely. This document is intended to guide clinicians to help them and their patients' get the most from a high quality medication review process and to ensure equity of practice across Shropshire.

# 3.0 Principles of Medication Review[3]

- All patients should have a chance to raise questions and highlight problems about their medicines
- Medication review seeks to improve or optimise impact of treatment for an individual patient
- The review is undertaken in a systematic way by a competent person
- Any changes resulting from the review are agreed with the patient
- The review is documented in the patient notes
- The impact of any change is monitored

# 4.0 Types of Medication Review

"Levels" of medication review were introduced by "Room for Review" in 2002 and are dependent on the level of detail of information used for the review.

| Level of Review | Description | Read Code |
|---|---|---|
| **Level 1** | Prescription Review – a technical review of the list of a patient's medicine | 8B3h |
| **Level 2** | Treatment Review – a review of medicines with the patient's full notes | 8B3S or 8B314 |
| **Level 3** | Clinical Medication Review – a face to face review of medicines and condition | 8B3x or 8B3V |

In 2008 the National Prescribing Centre published A Guide to Medication Review. [4] This is a framework for medication review with practical advice and examples. It describes different "types" of review, and recognises that different types of review each have a useful purpose and it is possible to have a useful discussion with the patient about their medication (face to face) without having the full notes (type2).

The types are:

| Types of Review | Description |
|---|---|
| **Type 1** | Prescription review: addresses issues relating to the prescription or medicines; the patient does not need to be present, nor access to full notes. |
| **Type 2** | Concordance and compliance review: addresses issues relating to the patient's medicine taking behaviour e.g. a MUR (Medicines Use Review) by community pharmacists. |
| **Type 3** | Clinical medication review: addresses issues relating to the patient's use of medicines in the context of their clinical condition. |

## 5.0 Who should do a medication review?

Level 2 and 3 reviews can only be carried out by an appropriate clinician. Doctors, clinical pharmacists and many advanced nurse practitioners will possess the competencies required to carry out effective medication review.

Practice nurses and non-medical prescribers should only carry out full medication review where they can demonstrate adequate pharmacological knowledge across the whole breadth of the patient's medication. They may perform disease specific reviews within their recognised areas of competency which should be read coded as such (e.g. asthma medication review or epilepsy medication review etc.). Disease specific reviews must NOT be recorded as full medication review unless the patient receives no other medication.

Practice support staff may be utilised to contribute to the medication review process e.g. manage the recall process, identify and highlight over or under ordering which may indicate poor compliance, or review records to identify patients who need additional monitoring.

## 6.0 Who should be reviewed?

The National Service Framework for Older People stated: “By 2002: All people over age of 75 should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6-monthly” This is mandatory for NHS organisations.[5]

Locally Shropshire CCG medication review advice for children is different to adults. When children are prescribed one or more regular medicines, the child must be reviewed face-to-face at least every month initially. After which the child must have a face-to-face review every two to three months thereafter. Alerts must be added to book the child face-to-face medication review at regular intervals.

All patients taking long term medication should receive an annual medication review, either level 2 or 3. However, it is reasonable to target full face to face clinical medication reviews (level 3) to those who are likely to benefit the most where practice capacity does not allow this as an approach for all.

Room for Review and the NPC’s ‘A Guide to Medication Review' suggested the following target groups should be prioritised for level 3 face to face medication review:

**Patients at risk of medicines-related problems**

- taking four or more medicines every day (especially in over 75’s)
- on a complex medication regimen or more than 12 doses in a day
- recently discharged from hospital
- recently transferred to care home
- frequent hospital admissions
- with multiple disease
- receiving medicines from more than one source e.g. specialist and GP
- significant changes to the medication regimen in the past 3 months or more than 4 changes in medication in the past 12 months
- taking higher risk medicines - those requiring special monitoring e.g. lithium; those with a wide range of side effects e.g. NSAIDs; or a narrow therapeutic range e.g. digoxin; or on drugs not commonly used in primary care
- symptoms suggestive of an adverse drug reaction
- longstanding use of psychotropic medication
- where non-compliance is suspected or known

**Special needs**

- older people
- residents in care homes
- 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
- literacy or language difficulties
- minority ethnic groups
- refugees and asylum seekers
- living alone or poor carer support
- recent falls

**Opportunities to improve care**

- new evidence or guidelines
- newly diagnosed long term condition
- out of date care plan
- newly registered patient
- patients identified by a screening tool (appendix 1)

Patients should be provided with written information about the review and how to prepare for it. See appendix 2 for a sample invite letter and patient information leaflet.

## 7.0 Contents of a Medication Review

**Level 2 and 3 Review should both check that:**

- **The medication is appropriate for the patient's needs**
  - Consider local and national evidence based guidelines – has this changed since the drugs were first initiated?
  - Review drugs of limited clinical value. See the PrescQIPP drop list for more information at http://www.prescqipp.info/headline-areas/the-prescqipp-drop-list
  - Consider appropriate duration of treatment / was long term treatment intended? E.g. aspirin and clopidogrel combinations for a maximum of 12 months
  - Is the dose and formulation appropriate?
  - Consider risks of medication e.g. falls risk in elderly
  - Is it preventing rapid symptomatic deterioration? E.g. furosemide for CCF, then continue.
  - Is it fulfilling an essential replacement function? E.g. levothyroxine- then continue.
- **The medication is effective**
  - Review measurable outcomes where appropriate (e.g. BP, $HbA_{1c,}$ MUST, etc.)
  - May require discussion with patient. Set and record treatment goals with patients where appropriate e.g. for chronic pain, diabetes mellitus etc.
- **The medication is cost effective**
  - Does it comply with local formulary choices? Would it be clinically appropriate to switch at this point?
- **Appropriate monitoring has been done both to assess clinical effectiveness and risk**
  - e.g. blood tests specific to medication or disease

In addition there should be an assessment made of:

- drug interactions
- adverse events
- any contra-indications
- compliance to treatment (over or under ordering)
- Potential for simplifying overall drug regimen
- need for lifestyle or non-drug interventions
- unmet need e.g. significant risk factors for CV disease or diabetes may require screening. AF patient may need CHAD2 VASC2 score to assess need for anticoagulation etc.

Where the patient is not present and any of the above screening identifies a potential issue or need to alter the medication regime the patient must be invited in for a level 3 face to face review.

**Level 3 face to face reviews should also review:**

- **Concordance**[6]
  - Explore patient's understanding of their condition and treatment
  - Explore patient's health beliefs
  - Explore patient's willingness to take the recommended medication regime and understanding of the impact of choosing not to take recommended medicines (if appropriate)
  - Involve patient in all prescribing decisions and come to a mutually agreed course of action
- **Self-management and OTC medication**

OTC medicines interact with prescribed medicines or adversely impact on clinical condition e.g. NSAIDs in CV disease or renal dysfunction

## 8.0 Medication review Tools

8.1 NO-TEARS is a mnemonic developed to prompt reviews to cover all required areas of a good quality medication review

**N= Need and indication**

**O= Open questions – explore patient perceived problems, compliance, patient's opinion on effectiveness etc.**

**T= Tests and monitoring**

**E= Evidence and guidelines**

**A= Adverse events**

**R=Risk reduction or prevention**

**S= Simplification and switches**

8.2 The **STOPP START tool** is useful for assessing whether a medicine is appropriate or worth starting in the elderly. This is available at: https://medicines.necsu.nhs.uk/?s=STOOP+START+TOOL

## 9.0 Documentation

Record:

- Action taken or recommendations (if the reviewer is not a prescriber) and **all**
- pertinent information that led to this decision
- Read Code appropriate to the review (Level 2: Treatment Review – a review of medicines with the patient's full notes 8B3S or Level 3 (also Type 3): Clinical Medication Review – a face to face review of medicines and condition 8B3x
- If an MUR has been undertaken by a community pharmacist this should be read coded as 8BMF
- Proposed follow up actions

## 10.0 Communication of changes

- The patient and/or carer must be informed of changes and have the opportunity to discuss or be involved in the decision making.
- If the patient is resident in a care home, uses a monitored dose system or uses the repeat dispensing service, the community pharmacy should also be informed of medication changes.

## 11.0 Follow up

If the reviewer is not a prescriber then any urgent recommendation for change must be followed up within 48 hours by the patients GP. The GP must document any actions or document any decision not to follow the reviewer's recommendation.

Mechanisms should be in place to ensure appropriate follow up e.g. by defining amended medication as "acute" or resetting medication review diary dates as appropriate to the patients' needs.

## 12.0 Auditable standards

- % practices with a written medication review procedure. Practices can audit their recorded medication reviews against the guidance in this document.

## 13.0 References


1. Medicines Partnership (2005). *Medicines related statistics. Task force on medicines partnership and the national collaborative medicines management services programme.* London; Medicines Partnership

2. Department of Health (2001) National Service Framework for Older People [Available from www.dh.gov.uk]

3. Task Force on Medicines Partnership and The National Collaborative medicines Management Services Programme (2002) *Room for Review: A guide to medication review: the agenda for patients, practitioners and managers.* NPC

4. National Prescribing Centre (2008) *A Guide to Medication Review A framework for medication review with practical advice.* NPC

5. National Institute for Health and Clinical Excellence (2009). NICE clinical guideline 76. Medicines Adherence

6. Royal Pharmaceutical Society of Great Britain (1997). *From Compliance to Concordance* London: RPSGB

7. Lewis, T (2004). *Using the NO TEARS tool for medication review*. *BMJ* Vol 329, 433-434

*8.* North of England CSU( Juluy 2016) *STOPP START medication toolkit supporting medication review*

9. North of England (Feb 2016) Clinical Medication Review A Practice Guide

10. NHS Scotland and the Scottish government (October2012) *Polypharmacy Guidance* Version 2

# Appendix 1:

## Medication Review Screening Tool

| | |
|---|---|
| Do you need help to obtain or take your medication? | Y/N |
| Do you have any side effects that you believe are caused by your medication? | Y/N |

**Any "Yes" answer to the above indicates a need for a medication review**

| | |
|---|---|
| Do you understand what your medicines are for? | Y/N |
| Do you understand when to take your medicines? | Y/N |
| Do you find it easy to take your medicines? | Y/N |
| Do you always remember to take your medicines? | Y/N |
| Do you always take all your medicines the way the doctor wants you to? | Y/N |
| Are you always able to order all your medications at the same time? | Y/N |
| Is your prescribed medication the only medication you regularly take? | Y/N |
| Do you think you medication is working effectively for you? | Y/N |
| Are your medicines easy to open and easy to use? | Y/N |

**Any "No" answer to the above indicates the need for a medication review**

Adapted from Morecambe Bay PCT-Medication Review for patients aged over 75 years

## Appendix 2

Practice address: Date:…/…./…...

**Dear……..**

Medication review

We wish to invite you to the practice for a routine review of your current medication.

The purpose of the medication review is to help you get the best from your medication. The medication review will take about 20 minutes. At the review, a GP or suitably qualified health professional will check that your medicines are working for you and that you are not having any problems with them. You will have the opportunity to ask any questions you may have about your medicines. If any changes need to be made to your medication, your agreement will be sought before changes are made.

Please read the enclosed leaflet to help you find out more about the medication review process and how to prepare for it.

Please make an appointment to have a medication review within the next 2 months.

Please bring all your medicines (which may include tablets, capsules, liquids, creams, ointments and inhalers) to the review. This includes prescribed medication as well as any herbal medicines or any medicines that you buy over the counter from the chemist or supermarket and also medication you no longer take.

Yours sincerely,

## Appendix 3

# Medication review

### *What is a medication review?*

A medication review is a private, confidential meeting between you and a GP or another suitably qualified health professional to discuss your medicines.

The aim of the medication review is to check that you are prescribed the most appropriate medicines and that you get the best out of those medicines.

Tests may be made to determine whether the medicine is working (e.g. blood pressure checks). Monitoring may be necessary for the type of medication that you are on.

You will be asked how you are getting on with your medicines; so inform your health professional of any problems you may be experiencing with your medicines.

You will have the opportunity to ask any questions you may have about your medicines.

If any changes need to be made to your medication, your agreement will be sought before changes are made.

A record of the review will be documented in your medical notes.

### *Preparing for your medication review*

- ❖ Mark the date and time of the appointment and who you are going to see for the medication review in your diary or calendar.

- ❖ Make a list of all medication that you take. This includes:
  - Any medicines that are prescribed for you.
  - Any medicines that you buy over the counter from the chemist or supermarket or other stores e.g. herbal medicines, vitamins etc.
  - Any medicines that you no longer take.

NB: If you are not able to or haven't managed to make a medication list, bring all your medicines to the medication review meeting.

- ❖ Make a list of questions that you may have about your medicines.

Some questions that you may wish to consider:

- Why is it important to take this medicine(s)?
- When and how to take the medicine(s)?

- How long is the medicine(s) to be taken for?
- How do I know the medicine is working?
- What should I do if I have problems with the medicine?
- Are there any medicines or food that I should avoid taking whilst on these medicine(s)?
- What will happen if I miss a dose of the medicine or stop taking it?

### After the medication review:

- Your regular GP will be informed of any medication changes agreed by you at the meeting.
- A summary of the meeting will be documented in your medical record.
- Any tests or referrals to other health care professionals if required will be agreed and acted upon.

Appendix 4

**Medication Review Tips by BNF Chapters**

General principles

- Check if there is current indication for the drug i.e. review need
- Check if there is clear indication for liquids/soluble medication where prescribed
- Formulary choice?
- Check for duplication of therapy e.g. 2 opioids
- Check if quantities are appropriate and synchronised
- Check if all necessary monitoring has been carried out? e.g. U& Es for thiazides, ACE-Is etc.
- Check if dosage schedule is appropriate e.g. Ramipril OD for hypertension and BD for CCF.
- End of life medication

**BNF Chapter 1 Gastro-intestinal**

H2 receptor antagonists/PPI

- Check if there is a clear indication for these. If not, then consider stopping as these may contribute to Clostridium difficile infection.
- For patients prescribed Lansoprazole fastabs because of gelatine content or if unable to take capsules, switch to Pantoprazole tablets.
- Switch Cimetidine to Ranitidine where treatment needs to be carried on as ranitidine has fewer interactions.

Laxatives

- Check if started due to opioid induced constipation and whether patient still on opioids
- Consider de-prescribing where multiple laxatives used. Stop the stimulant laxative and optimise dose of osmotic laxative.
- Check current use by patient and adjust quantity prescribed (stockpiling is an issue with these).

Domperidone and Metoclopramide

Check indication and dosage. Follow the MHRA recommendation available at http://www.mhra.gov.uk/home/groups/dsu/documents/publication/con300408.pdf

and http://www.mhra.gov.uk/home/groups/dsu/documents/publication/con418529.pdf

**BNF Chapter 2 Cardiovascular**

### Anti-hypertensives

- Consider de-prescribing if BP too low – stop one antihypertensive at a time if risks> benefit. Restart if BP rises above NICE target (140/90 for less than 80 years and 150/90 for over 80 years).
- Review concurrent prescriptions of ACE-I and ARBs or Aliskiren.
- Review doxazosin modified release as no benefit over normal release.

### Digoxin

Use lowest possible dose in elderly as increased risk of toxicity in elderly and in patients with CKD.

### Diuretics

Check if furosemide is not being used for managing drug induced side effects e.g. ankle oedema caused by calcium channel blockers.

### Statins

- Re-evaluate patient's risk profile as per NICE. Stop in metastatic disease.
- Check for interactions e.g. if patient on concurrent simvastatin 40 mg and amlodipine or diltiazem or verapamil- switch to atorvastatin 10 mg or reduce dose of simvastatin 20 mg ON. See http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON180637

### Ezetimibe

Check if prescribing is in line with NICE and local CCG guidelines.

### Omega 3

Stop prescriptions for Omega 3 where it was initiated post MI as per NICE guidance.

There is no evidence for its use in psychiatry, CKD or diabetes.

### Aspirin

Re-evaluate need if initiated for primary prevention.

- No evidence based potential benefit for enteric coated aspirin- so switch to soluble aspirin (which can be swallowed).
- Review concurrent use of enteric coated aspirin and PPIs.
- Doses >150 mg should be queried as no added benefit but more bleeding risk.

### Anti-coagulants

Warfarin: Check indication, duration and INR therapeutic range is appropriate.

- Check if INR is monitored regularly (maximum 12 weeks between INR's)
- Review patients where Time in Therapeutic Range (TTR) is <65% to address factors influencing the INRs and whether these can be addressed. Consider alternative anticoagulant where appropriate in patients where their TTR is unable to be improved upon.
- Review concurrent use of Warfarin and Aspirin/ other antiplatelet- consult with cardiology if in doubt whether combination should be carried on.
-

Direct Oral Anticoagulant (DOAC): Check indication, duration and dose is appropriate

- Review suitability of DOAC in patients with valvular heart disease or stenosis (aortic/mitral) in line with ESC recommendations https://www.escardio.org/Guidelines/Recommended-Reading/Heart-Rhythm/Novel-Oral-Anticoagulants-for-Atrial-Fibrillation
- Review concurrent use of DOAC and Aspirin/ other antiplatelet- consult with cardiology if in doubt whether combination should be carried on.

Warfarin and DOACS: On review check patient hasn't had any bleeding, bruising, thrombotic events, has had relevant blood tests (FBC, U+E, LFTS), change in any medications that may interact.

### Nitrates

Check if patient has not had chest pain in the last 6 months or has reduced mobility.

### Other points to consider:

- Alpha-blockers are generally not needed if the patient has a long-term catheter.
- Antimuscarinics should be reviewed after 3-6 months; if continence pads are used- then stop.
- Review long-term Quinine. See MHRA advice at :http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON085085

### BNF Chapter 3- Respiratory System

- Check inhaler technique.
- Check compliance.
- Check quantities of short acting beta agonists (e.g. salbutamol) prescribed.
- Review high dose inhaled corticosteroids in asthma- review 3 monthly and if control achieved, reduce dose gradually (by 50% every 3 months). Ensure the lowest effective dose is prescribed in patients with COPD.
- Theophylline monotherapy is not recommended for management of COPD.

## BNF Chapter 4- Central Nervous System

### Benzodiazepines

Consider withdrawal if appropriate

### Antipsychotics

Consider withdrawal in dementia patients with BPSD (behavioural and psychological symptoms of dementia) unless there is extreme risk of distress.

Gradual withdrawal in patient on long-term treatment with close monitoring recommended.

### Antidepressants

- Treat for 6 months after remission of symptoms for a single episode of depression.
- At least 2 years treatment needed for multiple episodes.
- Hyponatraemia can be an ADR for all antidepressants.
- Note increased risk of GI bleeds with concurrent NSAIDs & SSRIs.
- Risk of falls in elderly.
- Avoid prescribing dosulepin (fatal in overdose).

### Drugs for Dementia

- Reviews according to NICE guidelines- continue if having a worthwhile effect on cognitive, global, functional or behavioural symptoms.
- Ensure shared cared protocols are in place.

### Opioid analgesics

- Check if pain is severe enough to warrant a regular opioid as the risk of constipation/falls can outweigh benefit. If opioid not required-withdraw gradually. If opioid warranted, then review dose as per current pain.
- Buprenorphine & other opioid patches – review if pain unstable.
- Buprenorphine patches should not be started in primary care unless recommended by the pain services.
- Check if correct dosage & frequency prescribed for the correct brand of buprenorphine patch e.g. Transtec is applied every 96 hours & Butec/Reletrans every 7 days.
- For persistent pain prescribe modified-release preparations over immediate release once established on a stable dose.
- Review prescribing of low dose combinations analgesics as they contain sub-therapeutic doses e.g. Tramacet, Co-codamol 8/500, Co-dydramol etc.
- Ensure no duplication of therapy e.g. check that no more one paracetamol containing product is prescribed.
- Check directions include minimum interval between doses and maximum dose/ day
- Review patients on doses >120mg morphine or equivalent as risk of harm increased without the evidence of benefit

### BNF Chapter 5- Infections

- Only give antibiotics where indicated
- Review long-term (> 6 months) prophylactic nitrofurantoin use for UTI prophylaxis
- Systemic treatments for nail infections are more effective than topical treatments
- Review the need for long term antibiotic/ antifungal/ steroid creams and ointments

### BNF Chapter 6- Endocrine System

- Review gliclazide MR with a view of swapping to immediate release preparations
- Stop Pioglitazone in patients with heart failure or a history of heart failure or fractures especially post-menopausal women. See MHRA alerts at: http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON079277 and http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON084686
- Review prescriptions for Glibenclamide as risk of hypoglycaemia.
- Gliptins e.g. Sitagliptin should only be continued if there has been a $HbA_{1c}$ reduction of ≥0.5 % in 6months
- Exenatide & Liraglutide-continue only if there is a reduction of ≥ 1.0% points in $HbA_{1C}$ and ≥ 3% loss of initial body weight in 6 months.
- Bisphosphonates- review if treatment has been taken for 5 years or more; if risk of falls is low, they may no longer be needed, but note prolonged immobility is a risk factor for falls.
- Bisphosphonates-review if patient unable to sit upright especially if bed bound.
- Ensure patients on long-term steroids are prescribed bisphosphonates.
- Strontium should be stopped in patients with ischaemic heart disease, peripheral arterial disease, cerebrovascular disease or uncontrolled hypertension

### Chapter 8- Malignant Disease and Immunosuppression

Cytotoxics and immunosuppressants

Consider the expected outcome- do possible ADRS outweigh the possible benefit? Consider referring the patient back to the doctor who initiated them.

## BNF Chapter 9- Nutrition and Blood

### Sodium, potassium, magnesium, folate and iron supplements:

Check if still indicated. Treatment with iron supplements is usually for 3 months.

When stopping iron preparations, stop laxatives if they had been started for iron-induced constipation.

### Multivitamins

Check for a valid indication

### Vitamin D

- Prophylactic doses should not be prescribed for any age group.
- Refer to the CCG's vitamin D guidelines for more information.

### Calcium + vitamin D

- Consider stopping in bedbound patients in care homes who have not fallen over.
- Calcium and Ergocalciferol has insufficient prophylactic vitamin D dose. ( PrescQIPP Drop List)

### Vitamin B and Thiamine

Review with a view of stopping within 1 month of a patient being in a care home setting.

### Sip feeds

Check if still indicated and whether fortified food would be a better option. Ensure MUST scoring and ' Think food ' advice is reinforced. https://www.shropshireccg.nhs.uk/professional-resources/medicines-management/nutrition/primary-care-nutrition-resources/

## BNF Chapter 10-Musculoskeletal and Joint Disease

### NSAIDs

Possible risks outweigh the benefits in mild osteoarthritis hypertension, CCF and kidney disease.

Review long term use of topical NSAIDs .

### DMARDs/TNF Inhibitors

Check if treatment effective. If not,refer back to doctor who initiated

Check if shared care agreements are in in place

### Glucosamine and Chondroitin

These are not recommended for osteoarthritis by NICE

### BNF Chapter 11- Eye

- Eye drops/ointments-check need for preservative-free formulations (i.e. used more than 4 times a day).
- Review long term topical antibiotic preparations.

### BNF Chapter 13-Skin

- Creams have better moisturising effects compared to lotions.
- Creams/ointments- has the condition resolved or could continued use exacerbate the condition?
- Is the patient using sufficient emollient? See http://www.pcds.org.uk/clinical-guidance/atopic-eczema#management for more information.
- Step down eczema treatment if appropriate.
- Eflornithine cream- evidence for this is weak, so consider stopping.
- Minocycline for acne- increased risk of ADRs compared to oxytetracycline, lymecycline or doxycycline.
- Review bath and shower products and use emollients as soap substitutes

## Appendix 5

### Falls in the Elderly: Medication Review

Polypharmacy is a risk factor for falls. Medication reviews for patients on 4 or more medications should be carried out regularly.

| The following medications are implicated in falls- so review: |
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| **Any long-acting or long-term hypnotic or anxiolytic** |
| Reduce the dose if the medication cannot be stopped completely. Specific information on the reduction of benzodiazepines and Z drugs can be found as a NHS Clinical Knowledge Summary, http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal and insomnia guidance at http://cks.nice.org.uk/insomnia |
| **Antihypertensives/diuretics** |
| Stopping or reducing the dose of Calcium Channel Blockers may be indicated if the patient has ankle swelling resistant to diuretics. For people on combinations of antihypertensives, consider reducing the doses or stopping some of the drugs if signs of postural hypotension are evident. If diuretics are for dependent ankle oedema, consider other management strategies.<br>Optimise antihypertensive therapy bearing in mind the falls risk, mobility and postural hypotension |
| **Other CNS medication** |
| Review the need for antidepressants (e.g. amitriptyline) and antipsychotics( e.g. chlorpromazine) and anti-epileptic medication especially if used for atypical pain. Opiate analgesics- drowsiness and confusion which are common side effects can contribute to falls.<br>Medication for vertigo e.g. prochlorperazine |
| **Sedating antihistamines**<br>E.g. Chlorpheniramine, cinnarizine, promethazine etc. |
| **Anticholinergic drugs** (e.g. oxybutynin) for bladder spasm or other drugs with anticholinergic side effects (e.g. tricyclic antidepressants). |

| **Ensure calcium and vitamin D is prescribed for those with a falls history.** |
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