Practice Plus Webinar

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Practice -

Steve Williams

Lead Clinical Pharmacist PrescQIPP Practice Plus International Journal of Pharmacy Practice, 2023, 31, 126–152 https://doi.org/10.1093/ijpp/riad001 Advance access publication 1 March 2023 Review Article



Barriers and facilitators of implementing proactive deprescribing within primary care: a systematic review

Daniel A. Okeowo^{1,2,*,0}, Syed Tabish R. Zaidi^{1,2}, Beth Fylan^{2,3,4} and David P. Alldred^{1,2}

School of Healthcare, University of Leeds, Leeds, Yorkshire, UK,

²NIHR Yorkshire and Humber Patient Safety Translational Research Centre, Bradford, UK,

³School of Pharmacy and Medical Sciences, University of Bradford, Bradford, Yorkshire, UK, and

⁴Yorkshire Quality and Safety Research Group, Bradford Institute for Health Research, Bradford, Yorkshire, UK

*Correspondence: Daniel A. Okeowo, School of Healthcare, University of Leeds, Leeds, UK. Email: umdao@leeds.ac.uk

Abstract

Objective Proactive deprescribing – identifying and discontinuing medicines where harms outweigh benefits – can minimise problematic polypharmacy, but has yet to be implemented into routine practice. Normalisation process theory (NPT) can provide a theory-informed understanding of the evidence base on what impedes or facilitates the normalisation of routine and safe deprescribing in primary care. This study systematically reviews the literature to identify barriers and facilitators to implementing routine safe deprescribing in primary care and their effect on normalisation potential using NPT.

PubMed, MEDLINE, Embase, Web of Science, International Pharmaceutical Abstracts, CINAHL, PsycINFO and The Cochrane Library were searched (1996–2022). Studies of any design investigating the implementation of deprescribing in primary care were included. The Mixed Methods Appraisal Tool and the Quality Improvement Minimum Quality Criteria Set were used to appraise quality. Barriers and facilitators from included studies were extracted and mapped to the constructs of NPT.

Key findings A total of 12,027 articles were identified, 56 articles included. In total, 178 barriers and 178 facilitators were extracted and condensed into 14 barriers and 16 facilitators. Common barriers were negative deprescribing perceptions and suboptimal deprescribing environments, while common facilitators were structured education and training on proactive deprescribing and utilising patient-centred approaches. Very few barriers and facilitators were associated with reflexive monitoring, highlighting a paucity of evidence on how deprescribing interventions are appraised.

Summary Through NPT, multiple barriers and facilitators were identified that impede or facilitate the implementation and normalisation of deprescribing in primary care. However, more research is needed into the appraisal of deprescribing post-implementation.

Keywords: Inappropriate prescribing; adverse drug reactions; primary care; medicines management; medication review

Table 5 Main barriers and facilitators to implementing proactive deprescribing in primary care

Construct of NPT	Barriers of implementation	Facilitators of implementation			
Coherence	 Negative deprescribing perceptions Patient and HCP strong belief in continuation of medicines Limited understanding of HCP roles in deprescribing Uncertainty and lack of information about how to deprescribe Lack of interest in deprescribing 	deprescribingBelief in the consequences of PIMs and ADRsDeprescribing accepted as scope of practice			
Cognitive participation	 HCPs apprehensive to discontinue medicines Patient resistance to deprescribing recommendations Lack of internal and external collaboration Lack of proactively identifying patient needs 	 Engagement of HCPs and patients Positive relationships between HCPs and patients MDT Involvement Patient-centred approach 			
Collective action	 Sub-optimal deprescribing environment Strong prescribing culture Poor communication and information sharing Lack of confidence to deprescribe 	 Availability of deprescribing resources and support for HCPs Supportive guidance for patients Collaborative MDT sharing workload Presence of predefined deprescribing process Confidence in deprescribing Requiring medicines to have an associated indication for use 			
Reflexive Monitoring	• Deprescribing tools not used as initially intended	 Individualised feedback on prescribing for GPs 			

HCP, healthcare professional; PIMs, potentially inappropriate medicines; ADRs, adverse drug reactions; MDT, multidisciplinary team

Get an SMR PLAN !

Prepare Listen

Agree

Notes

READ MY MOTES BEFORE I ARRIVE ...



THEY WANT TO THE ONLY MEDICINE THAT MAKES ME FEEL BETTER!



Preparing for a medication review – how IMPACT can help you

Katie Smith, Director of Clinical Quality

July 2023

Funded by the NHS for the NHS

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What is IMPACT?

- Improving Medicines and Polypharmacy Appropriateness Clinical Tool
- Suggestions to optimise medicines use and practical info on how to stop if needed
- Highlights high risk medicines and measures to improve patient safety to prevent incidents of avoidable significant harm
- Summarises information from lots of sources for UK medicines
- Information evidence based and all references hyperlinked
- Information presented in two tools evidence summary and data pack





IMPACT - Improving Medicines and Polypharmacy Appropriateness Clinical Tool

This bulletin provides suggestions for consideration by commissioning organisations and clinicians to optimise medicines use, and provide practical advice (where it is available) about how to safely stop/ discontinue/withdraw a medicine and issues to consider. For person-centred care, clinicians should ask people what matters to them so that their treatment and care can be personalised. A discussion about medicines benefits and risks and possible consequences of different options should take place with the person to enable shared decisions with them about whether to continue or stop a medicine. If it is decided that therapy is appropriate, it should be continued. Where it is decided to stop a medicine because the risk of continuing outweighs the benefit to the patient, the information in this bulletin can be used as a practical decision aid, in conjunction with other relevant, patient specific data.

Background

The World Health Organisation (WHO) aimed to reduce severe avoidable medication related harm by 50% globally by 2022. [WHO 2017] PrescQIPP have developed resources to support the WHO Medication without harm challenge, which are available here: <u>https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/</u>

In September 2021 the national overprescribing review for England (Good for you, good for us, good for everybody) stated that 'Prescribing can be seen as a form of problem-solving, with a medical condition as the problem and a medicine as the solution. But more often than not medicines can only manage a condition, not cure it, and the wider needs and preferences of the patient may change. The key to stopping overprescribing is medicines optimisation: ensuring that patients are prescribed the right medicines, at the right time, in the right doses. In some cases, medicines optimisation may lead to a patient being offered additional medication, or having their dose increased, but it also provides a framework for reducing and stopping overprescribing. Stopping a medication may be just as challenging in terms of weighing the benefits or providing support as starting it. Deprescribing seeks to apply best practice in prescribers, and the same level of support from pharmacists, and from guidance, data and insight, even from the pharmaceutical manufacturers, to get the best results. And just as with prescribing, it should place patients at the centre of the process, to ensure medicines optimisation.' [DHSC 2021]

The NHS in England and Wales spent £9.794 billion on medicines in primary care in 2019/2020. [NHS Digital 2020, Welsh Government 2020] The NHS in Scotland spent £1.0626 billion on medicines in primary care in 2019/2020. [Public Health Scotland 2021]. It is estimated that medicines worth over £300 million are wasted each year in England. The cost to the NHS of people not taking their medicines properly and not getting the full benefits to their health has been estimated at over £500 million a year. [NHSE 2015, YHEC 2010]

When talking with people about their medicines, health-care professionals should ask the person what matters to them and work together with them to reach a decision about care. Health care professionals should review whether the medicines are still clinically appropriate and be able to discuss the risks, benefits and possible consequences of different options. Since July 2019, clinical pharmacists working in Primary Care Networks are responsible for undertaking adherence-centred medication reviews in

How to use IMPACT for a medication review

<u>https://www.prescqipp.info/our-resources/bulletins/bulletin-268-impact</u> Two options -

- 1. Look up each medicine in the IMPACT bulletin, click through to the original references for more information, manually work out priority for reviewing
- Produce a medicines list using the IMPACT data pack, which you can prioritise based on clinical and deprescribing risk, links to deprescribing algorithms



1. Using the IMPACT document

5

6

Interactive contents page allows you to click easily between

medicines

Contents Gastrointestinal system

Loperamide

Antispasmodics H2 blockers/PPIs Infantile colic products Laxatives

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IMPACT layout

- Classes & individual medicines
- PrescQIPP resources
- Referenced
- Deprescribing algorithms
- Lifestyle advice
- Clinical risk & deprescribing priority
- Each page has key at top, back to contents at bottom

KET CR = Clinca	ai risk ievei	DP = Deprescribing priority if no longer needed or indica	tea n = nign	M = Medium	L-	= LOV	N
Drugs	Considerati current indi	ons to optimise medicines use after checking for a valid cation	Withdrawing	Withdrawing/tapering and lifestyle advice			DF
Cannabis based medicinal products	physician w sclerosis. Tr has had at le	vith THC:CBD spray should be initiated and supervised by a th specialist expertise in treating spasticity due to multiple eatment should only continue after a 4-week trial if the per east a 20% reduction in spasticity-related symptoms on a ent-reported numeric rating scale. [NICE NG144]		alist.		н	н
	Cannabis ba pain.[<u>NICE</u> I	sed medicinal products should not be used to manage chro <u>IG144</u>]	onic	Refer to doctor who initiated treatment. Offer advice about eating a Mediterranean diet (plenty of fruit, vegetables, fish and less meat and butter), stopping smoking, drinking alcohol. [CKS rheumatoid arthritis]			
DMARDs (e.g. methotrexate, sulfasalazine penicillamine, leflunomide, hydroxychloroquine)	Not approp dementia. [l Methotrexa	penicillamine if there is no improvement within 1 year. [B] iate in nursing home patients with advanced/end stage Parsons 2015, CKS Dementia] te is a weekly dose, to minimise errors, only one strength uld be prescribed and dispensed. [BNF]	treatment. Offer advice a Mediterranea vegetables, fit butter), stopp				м
<u>Glucosamine</u> (including products containing chondroitin)	1	nended by NICE for treatment of osteoarthritis (OA). Purch red. [NHSE/NHSCC 2019, NICE CG173]	overweight), r exercises, psy there is assoc	on self care strategies for , e.g. weight loss (if nuscle strengthenin chological support i iated stress, anxiety se of analgesia. [CKS	F	L	L

DP = Deprescribing priority if no longer needed or indicated

 $H = Hi\sigma h$

Drugs	Considerations to optimise medicines use after checking for a valid current indication	Withdrawing/tapering and lifestyle advice	CR	DP
NSAIDs (e.g. ibuprofen, mefenamic acid, naproxen, diclofenac, dexibuprofen, flurbiprofen, ketoprofen, dexketoprofen, aceclofenac, etodolac, celecoxib, indometacin, meloxicam, nabumetone, piroxicam, sulindac, tenoxicam, etoricoxib, parecoxib)	Is an NSAID still needed/appropriate? For example, long term treatment of gout but no prophylaxis is prescribed [STOPP-START], chronic primary pain [NICE NG193]. Do the known possible adverse drug reactions outweigh the possible benefits? For example >3 months use for symptom relief in mild osteoarthritis, use in patients with severe hypertension/heart failure/ chronic renal failure. [STOPP-START, Garfinkel 2010] Has PPI prophylaxis been prescribed if also taking concurrent antiplatelet/ anticoagulant treatment? [STOPP-START] NSAIDs may influence the risk of falls by adversely affecting the cardiovascular or central nervous system (e.g. orthostatic hypotension, bradycardia, sedation, sleep disturbance, confusion, dizziness). [Lee 2021] If topical NSAIDs are continued indefinitely, review the need for use; short courses are generally advised for piroxicam, felbinac, diclofenac and ketoprofen. [BNF]	No tapering needed. [Medstopper] Offer advice on self care management strategies for osteoarthritis, e.g. weight loss (if overweight), muscle strengthening exercises, psychological support if there is associated stress, anxiety, depression, use of analgesia. [CKS Osteoarthritis] PrescQIPP NSAID deprescribing algorithm	м	м

Return to contents

Musculoskeletal

Clincal risk level

Opioid deprescribing algorithm

Opioid analgesics on repeat prescription (>3 months) Dependence Forming Medicines (DFM) deprescribing algorithm^{1.4} - Updated April 2023

Include patients suitable for managed withdrawal who:

- Are taking the equivalent of 120mg morphine or greater/24 hours (SIGN guidelines recommend 50-90mg or greater)². Searches available to help identify patients.
- Are not achieving at least 30% pain reduction (through review)
- No longer have an underlying painful condition as it has resolved
- Have received a definitive pain-relieving intervention (e.g. joint replacement)
- Have developed intolerable side effects
 Are engaged with the process: willing committed, compliant, have adequate social support and can be reviewed regularly

Review at face to face appointment. Aim to ensure that the same healthcare professional is seen.

- Agree outcome(s)
- Explain benefits and rationale for stopping, i.e. explain tolerance, dependence, adverse effects and risks of continuing
- Review emotional influences and physical co-morbidities
- Ensure close collaboration between patient, carer and all members of healthcare team, e.g. mental health providers or specialists
 Ensure psychosocial support for anxiety
- Ensure psychosocial support for anxiety related to tapering
- Agree tapering schedule, refer to refer to
 PrescQIPP bulletin 284: Chronic pain

Exclude (ensure regular review of therapy and refer for special support): • Specialist/CMHT /substance misuse

- Potential substance misuser
- Drug seeking behaviour or where there is strong evidence that the patient is diverting his/her medications to others, taking medication prescribed to others or requesting early
- prescriptions. Ensure review of early requests • Patients who are failing to derive benefit from large doses of opioids
- (greater than oral morphine equivalent of around 300mg/day)

Refer to specialist support for assessment and support in line with commissioning policies (e.g. addiction services, mental health and pain management services)

Prescriber responsibility:

 Deprescribing is the prescribers responsibility and regular review is vital.

 Have adequate training - see resources from Toolkit for tackling chronic opioid use in non-cancer pain (Ensure Licence agreements followed)
 Good communication through whole healthcare team to ensure consistency

 Refer to <u>PrescQIPP bulletin 284:</u> <u>Chronic pain</u>

Review patient's understanding of pain https://vimeo.com/187991515/b6374f1254

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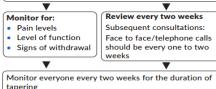
https://www.youtube.com/watch?v=OYOi1AD5mOk

Psychosocial support for anxiety related to taper Low intensity psychological interventions:

- Individual non-facilitated self-help, individual guided self-help, psychoeducational groups
- High intensity psychological interventions:
- Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) or applied relaxation

Agree dose reduction schedule with patient

- Consider starting by reducing the total opioid dose by 10% of the original dose. Consider giving the person additional control over the process of dose reduction; people who have some control over their own dose reduction schedule often have a more successful withdrawal. Slow the rate of taper or pause if withdrawal symptoms are significant for the patient.⁴
- If appropriate, convert to morphine equivalent daily dose to allow dose reduction in smaller steps.
- For dose equivalence see: PrescQIPP bulletin 284: Chronic pain and RCOA dose equivalent and changing opioids



Opioid analgesics on repeat prescription (>3 months) Dependence Forming Medicines (DFM) deprescribing algorithm¹⁻⁴ - Updated April 2023

PrescQIPP resources	Other resources (for prescribers and patients)			
PrescQIPP Opioids aware audit webinar	Toolkit for tackling chronic opioid use in non cancer pain (Ensure Licence agreements followed)			
PrescQIPP Opioids aware webinar	RCOA dose equivalent and changing opioids			
PrescQIPP bulletin 284: Chronic pain	CDC Pocket Guide: Tapering Opioids for Chronic Pain			
PrescQIPP Silver Award Winner 2019- Blue-folder clinics to facilitate reduction of inappropriate opioid, pregabalin, hypnotic and benzodiazepine prescribing to improve patient outcomes (East Norfolk Medical Practice)	Pain Concern Navigator Tool			
PrescQIPP Annual Award Winner 2019. High dose opiate reduction in Great Yarmouth and Waveney (NHS Great Yarmouth and Waveney CCG)	Opioid Risk Tool to assess risk of abuse			
Reducing opiate prescribing in pain (NHS Great Yarmouth and Waveney CCG)	Acceptance and Commitment Therapy (ACT)			
	The Pain Toolkit			
	Live Well with pain			

References

- Faculty of Pain Medicine. Supported by Public Health England. Opioids Aware: A resource for patients and healthcare professionals to support
 prescribing of opioid medicines for pain. <u>http://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware</u> Accessed 22/03/23.
- Scottish Intercollegiate Guidelines Network. Management of Chronic Pain. SIGN 136. December 2013, revised August 2019. <u>https://www.sign.ac.uk/our-guidelines/management-of-chronic-pain/</u>
- National Institute for Health and Care Excellence. Generalised anxiety disorder and panic disorder in adults: management. Clinical guideline [CG113]. January 2011, updated June 2020. www.nice.org.uk/CG113
- 4. National Institute for Health and Care Excellence. Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. NICE guideline [NG215]. April 2022. https://www.nice.org.uk/guidance/ng215



2. Using the IMPACT data pack

Home > Our resources > Bulletins > Bulletin 268: IMPACT

Bulletin 268: Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT)

Medicines safety Best practice Medicines optimisation Polypharmacy and deprescribing Bulletin

This resource is an update to the Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT). It identifies clinical and deprescribing priority with recommendations and considerations for appropriately continuing or stopping medicines.

Links to PrescQIPP and other deprescribing algorithms are included where available and the tool will be regularly updated as new algorithms become available.

A data visualisation is also available which shows prescribing spend for each section. The tool can be filtered to produce a list of meds for individual patients that highlights deprescribing priority. This can be used to support clinical decision making as part of a structured medication review and will help inform shared decision making.

Downloads Webinar

Visual data pack

Introduction IMPACT Bulletin Background References



Visual data pack

Introduction IMPACT Bulletin Background References

Data pack layout

- No direct links to references
- Deprescrbing algorithms
- Can exclude
 cost data

Show Data:	Region:	Integrated Care Boar	'd: ▼	(All)	1:	▼ (All)	PCN:	•	(All)	e:
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RNE class / Dangs	Considerations to optimise medicin for a valid current indication	ues use after checking	Withdra advice	awing/tapering and li	festyle	Clinical Risk	Deprescribing priority if no longer needed / indicated	Links to sup tools/ deprescribir algorithms	 BNF class / Drugs 	
PPIs (e.g. esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole)	How long have they been prescribed at ful Risk of bone loss and fractures with PPI use in the elderly. [Scotland Polypharmacy Gui Is an NSAID still being taken? If no, stop other risk factors for GI bleeding inclu- antiplatelet, warfarin, DOAC etc.; histor bleeding. If not used for gastroprotection, stop PPI if ulcer, GI bleeding or dyspepsia for 1-year, Clostridium difficile infection. [Bee If PPI use is appropriate, prescribe as gene capsules at the lowest of PPIs should be reviewed 4-8 weeks after sta where appropriate. For long term treatment, should be completed Measurement of serum-magnesium conce before and during prolonged treatment v especially when used with other drugs that digoxin.[BN Limited benefit in people with limited life efficiency of gastrointestinal bleeding, peptic concomitant use of NSAIDs and st Cimetidine has some anticholinergic activi dose to control symptoms. [Scotland Po	a >1 year at high dose, particularly idance 2018, Beers criteria 2019] PPI [Medstopper] but consider sting age >65 yrs; taking an y of peptic ulcer disease or GI (there has been no proven peptic continued use may contribute to ers criteria 2019, NG199] eric omeprazole or lansoprazole dose needed. arting treatment and discontinued a medicine review of PPI therapy d annually. entrations should be considered with a proton pump inhibitor, cause hypomagnesaemia or with [F] expectancy unless there is a recent c ulcer, gastritis, GORD, or the eroids. [Thompson 2019] ity (PPIs have none), use lowest	Reduce PPI and PPIs ca needed conce If used once at withdraw the dru occur, so	festyle/self-management a [CKS Dyspepsia] the frequency and dose. Si advise use on demand or care (purchase OTC). In be stopped without taper I. If rebound hypersecretio rn, then the dose of PPI ca reduced gradually. d daily for more than 3-4 w dose by 50% every 1 to 2 v (25% of the original dose a ral symptoms have been se us. If any withdrawal symp back to approximately 75% isly tolerated dose. [Medst	top the as self ring if m is a an be weeks weeks. and no sen, stop ptoms % of the	High	High	https://www.pp pp.info/media: attachment-5- long-term-sai and- sastroprotect deprescribin algorithm-ad 20.pdf	5095/ ppis- lety- ion- uz-	

Dress

Data pack layout

- No cost data gives a cleaner layout for individual medication review
- Can sort by clinical risk, deprescribing priority or alphabetically

Visual data pack

Introduction IMPACT Bulletin Background References

Use the filters below to customise your IMPACT report.



	Show Data:		Region:	Integrate	d Care Board:		Location:		PCN:		Practice:
No	•	(All)	•	(All)		• (All)		•	(All)	•	(All) 🔻
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	Clinical risk								Deprescribing	Links to supp	ort
	B Deprescribing	priority	ations to optimise medici d current indication	ines use after che	cking W ad	/ithdrawing/tap dvice	ering and lifestyle	Clinic Risk	al priority if no longer needed / indicated	tools/ deprescribing algorithms	
Chapter	PPIs (e.g. esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole)	Risk of bon in the elder Is an NSA other : antiplate If not used ulcer, GI b Clo If PPI use PPIs should where appro Measurer before : especially Limited ber history or con	have they been prescribed at fi e loss and fractures with PPI u ly. [Scotland Polypharmacy Gr AID still being taken? If no, sto risk factors for GI bleeding inc leet, warfarin, DOAC etc.; histo bleeding for gastroprotection, stop PPI leeding or dyspepsia for 1-year stridium difficile infection. [Bo is appropriate, prescribe as ger capsules at the lowes l be reviewed 4-8 weeks after s opriate. For long term treatmen should be complet ment of serum-magnesium com and during prolonged treatmen when used with other drugs tha digoxin.[B tefft in people with limited life f gastrointestinal bleeding, pep ncomitant use of NSAIDs and s e has some anticholinergic acti control symptoms. [Scotland]	se >1 year at high dos uidance 2018, Beers o p PPI [Medstopper] I luding age >65 yrs; t yry of peptic ulcer dis g. if there has been no p r, continued use may eers criteria 2019, NC neric omeprazole or 1 t dose needed. tarting treatment and t, a medicine review ed annually. centrations should be t with a proton pump t cause hypomagness NF] expectancy unless th tic ulcer, gastritis, G steroids. [Thompson] vity (PPIs have none	se, particularly criteria 2019] but consider aking an sease or GI proven peptic contribute to G199] lansoprazole l discontinued of PPI therapy e considered inhibitor, aemia or with RDD, or the 2019]), use lowest	[CKS D Reduce the frequent PPI and advise use . care (purc PPIs can be stoppe needed. If rebound concern, then the reduced dose by 50% Once at 25% of the ithdrawal symptom the drug. If any wi your, go back to app	management advice. yspepsia] ty and dose. Stop the on demand or as self hase OTC). d without tapering if hypersecretion is a dose of PPI can be gradually. ore than 3-4 weeks. original dose and no shave been seen, stop thdrawal symptoms roximately 75% of the l dose. [Medstopper]	Hig	h High	https://www.pres pp.info/media/50 attachment-5-pp long-tent-and- gastroprotection deprescribing- algorithm-adult 20.pdf	957 18:- X:- 2:-

IMPACT limitations

- Should **not** be used as the only information source when doing a medicines review
- Does **not** replace shared decision making with the patient
- Clinical risk/deprescribing priority intended as a guide to start a discussion, **not** absolute value
- Does not replace your clinical knowledge



How IMPACT can help

- Does each medicine have a current valid indication?
- Look at the info for each medicine in IMPACT to see if any of the medicines need optimising OR if withdrawal should be considered
- Look at clinical risk/deprescribing priority in conjunction with the patients wishes to continue or stop medicines



Where to access IMPACT

https://www.prescqipp.info/our-resources/bulletins/bulletin-268-impact/

IMPACT - Improving Medicines and Polypharmacy Appropriateness Clinical Tool

This bulletin provides suggestions for consideration by commissioning organisations and clinicians to optimise medicines use, and provide practical advice (where it is available) about how to safely stop/ discontinue/withdraw a medicine and issues to consider. For person-centred care, clinicians should ask people what matters to them so that their treatment and care can be personalised. A discussion about medicines benefits and risks and possible consequences of different options should take place with the person to enable shared decisions with them about whether to continue or stop a medicine. If it is decided that therapy is appropriate, it should be continued. Where it is decided to stop a medicine because the risk of continuing outweights the benefit to the patient, the information in this bulletin can be used as a practical decision aid, in conjunction with other relevant, patient specific data.

Notes for the IMPACT table

In the IMPACT table, the lists of example medicines are not exhaustive. Links to PrescQIPP resources are included where relevant.

Clinical risk classifies the risks versus the benefits of continuing therapy based on usual maintenance doses as a general indication for classes of medicines. The clinical risk is not absolute and is intended as a guide. Risks may differ for individual patients depending on various factors e.g. age, co-morbidities etc.

Deprescribing priority is to help in situations where, for example a patient is on 20 drugs and 10 could be changed. It may not be possible (or desired by the clinician/patient) to stop these all at once, so criteria are needed to help decide which to do first. The priority has been assigned based on clinical risk and medicine/patient safety factors first, and only considers cost when all safety issues are equal. When reviewing treatment for individual patients, it is important to consider the cumulative risks of medicines taken together and adjust the clinical risk and deprescribing priority accordingly using clinical judgement. This bulletin provides suggestions for consideration by commissioning organisations and clinicians to optimise medicines use, and provide practical advice (where it is available) about how to safely stop/ discontinue/withdraw a medicine and issues to consider. For person-centred care, clinicians should ask people what matters to them so that their treatment and care can be personalised. A discussion about medicines benefits and risks and possible consequences of different options should take place with the person to enable shared decisions with them about whether to continue or stop a medicine. If it is decided that therapy is appropriate, it should be continued. Where it is decided to stop a medicine because the risk of continuing outweighs the benefit to the patient, the information in this bulletin can be used as a practical decision aid, in conjunction with other relevant, patient specific data.





Training video for

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