Specialist support for Structured Medication Reviews (SMRs) in complex patients

Collaborating organisations: SEL ICS, The Albion Surgery (Bexley), The Westwood Surgery (Bexley), Kingston University (for evaluation)

Description

The purpose of this mini-pilot was to test the impact of specialist input in supporting generalist PCN pharmacists when undertaking SMRs in patients with complex needs, for example those over the age of 80 years old, on more than 10 medicines or those who are frail.

What problem is it trying to solve to tackle overprescribing?

- The identification and prioritisation of people who would benefit most from a SMR is currently inconsistent and not routine practice. There is a lack of confidence across the system to have shared decision-making conversations that facilitate deprescribing, with clinicians reluctant to challenge senior or specialist colleagues, or patients and their relatives/carers, to deprescribe specialist medicines.
- Clinical guidelines focus on single long-term conditions and do not account for the complexities or multi-morbidities, frailty, non-drug treatments and deprescribing.
- The principles of medicines optimisation and deprescribing through the use of SMRs are not currently reflected in the education, training and professional development of all healthcare professionals.

Implementation

- The Primary Care Network (PCN) and GP practices that were to participate in the mini-pilot were identified.
- The PCN pharmacist was briefed by the SEL ICS Overprescribing Lead Pharmacist on how to approach patient centred SMRs, providing the appropriate resources, tools and guidance.
- A process for the PCN pharmacist seeking specialist input was decided, as follows:
  - An in-person meeting was arranged so that the set up within the GP practices could be fully understood and the appropriate patient cohort identified.
  - A virtual discussion between the PCN pharmacist and SEL ICS Overprescribing Lead Pharmacist was scheduled to discuss patients, both pre and post SMR. Initially, this discussion encompassed all patients and then became more selective based on the self-directed need of the PCN pharmacist.
- The methods for evaluation of the mini-pilot were determined:
  - Quantitative – collection of data on medicines outcomes and the achievement of patient agreed priorities following SMR, and who within the multi-disciplinary team the PCN pharmacist liaised or referred the patient to.
  - Qualitative – interviews conducted with the PCN pharmacists.

Outcomes

- SMRs were conducted with 18 patients as part of this mini-pilot, with an average age of 87.3 years (81-92 years).
- There was a 12% reduction in the number of medicines prescribed to the patient cohort post-SMR (1.4 medicines stopped per patient). A range of different types of medicines were deprescribed.

	Age	Pre SMR	Post SMR	Patient priorities and goals agreed	Comments	Medicines outcomes*					
						1	2	3	4	5	6	7
1.	92	11	9	To reduce meds. Spoke with carer, as pt has dementia.	*Mebeverine & paracetamol stopped, omeprazole dose reduced from 40mg to 20mg OD*		2	1	1			
2.	87	10	8	To reduce breathlessness, BP low but patient asymptomatic.	*Asthma reviewed. Spacer prescribed. To use salbutamol prior to going upstairs. Gabapentin and amlodipine stopped*		2					
3.	95	11	10	Pain management.	*To use pain chart to record timing of pain. On Butec 20, analgesia not increased. Laxido stopped as Docusate is enough for bowel movement.*		1					
4.	92	9	6	To reduce polypharmacy. Spoke with daughter, patient has dementia.	*Aspirin, lansoprazole and simvastatin stopped. Takes for primary prevention*		3					
5.	93	15	12	To improve pain.	*Butec dose ↑ . paracetamol stopped as not helping.*		3	1				
6.	92	12	12	To reduce Pain in knee.	*Knee support bandage advised. No deprescribing done. To continue with current pain med.*							
7.	89	12	10	Pain control. Despite high ACB score with amitriptyline.	*Patient report it is helping with pain. Pt & son not willing to stop. To continue Amitriptyline. Folic acid and famotidine stopped. Ferrous sulphate dose reduced*		2	1				
8.	85	11	10	Patient concerned about kidney function – wanting to reduce furosemide dose	*Mebeverine & paracetamol stopped, omeprazole dose reduced from 40mg to 20mg OD*		2	1		1		0
9.	86	10	9	Constipation was main concern – senna not working, discussed OTC options	*Senna stopped and patient has been using dulcolax which has been affective.*		1					
10.	80	14	12	Main concern was LFT BT. – Stopped statin and request repeat BT	*BT in range now.*		2					
11.	86	14	12	Patient is hoping to reduce number of medications	*BP medication stopped due to low BP*		2					
12.	86	10	9	Patient would like to stop metformin due to embarrassing side effects	*Diabetic nurse reviewed and would like patient to continue.*		1					
13.	87	10	10	Patient felt unsure if could attend surgery unaided. Only discussed briefly over the phone			0					
14.	89	10	9	Review of angina medication	*Patient felt nicorandil not needed.*		1					
15.	86	11	9	Main concern was constipation.	*Hydration encouraged, osmotic laxative discussed.*		2	1		1		
16.	81	13	13	Main concern was wound dressing following operation.	*Task to admin team to arrange.*		0	1				
17.	86	12	11	Main concern was urinary frequency.	*Discussed trialing without tamsulosin*		1	1				
18.	81	14	13	Patient was wanting to reduce tablet burden			0	1				

*Medicines outcomes: (1) Continued (2) Stopped (3) Dose/frequency changed (4) Cost-effective preparation (5) Alternative preparation (6) Newly started (7) SDM – now adherent

Intended outcomes:

1. For the PCN pharmacists to build their own network to support decision making in complex patient cases
2. To reduce the number of medicines prescribed, or reduce the number of doses prescribed, in the selected patient cohort
3. For the PCN pharmacists to become more confident to deprescribe medicines

- Using a shared-decision making process meant that all patient priorities were achieved during the SMRs.
- The PCN pharmacists mostly liaised or referred patients to a GP at the practice.
- Feedback from the PCN pharmacists on how they felt their practice was impacted by the mini-pilot was captured as part of the interviews.

Top Tips:

1. Identify a patient case load and ensure there is the appropriate protected time for the pharmacist to undertake the SMRs.
2. Assign a named GP to support the pharmacist to implement changes.
3. Ensure there is room availability for conducting face to face reviews.

> Realising I don't have to make all the decisions, which can create anxiety as a pharmacist, helped a lot.
>
> Thinking about the SMR more as a discussion that I can take to other members of the MDT or specialists as feedback helped me to feel more confident overall

> I learnt about pain chart, my first time of seeing it. Also about Pain Scotland's video to help patient appreciate pain meds. I appreciate the importance of taking holistic approach by signposting patient to social prescriber for daily living support

> I have learnt that shared decision making is important and ensure the patient is invited to discuss their concerns at the beginning of appointment to help guide and tackle problems with overprescribing

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