HOSPICE WEST AUCKLAND

DE-PRESCRIBING IN PALLIATIVE CARE

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POLYPHARMACY

Number of medicines that a patient is taking simultaneously, typically five or more

Appropriate
- multiple mobidities/complex conditions
- benefit > risk

Problematic
- risk > benefit

What is best practice?
- BPAC recommends regular review and de-prescribing

Duerden, M., Avery, T., & Payne, R. (2013) *Polypharmacy and medicines optimisation. Making it safe and sound.* London: The Kings Fund.

DE-PRESCRIBING

The process of tapering or discontinuing medication, with the aim of managing polypharmacy (Thompson & Farrell, 2013)

Improves (Lindsay, et al., 2015)
- patient safety
- quality of life
- decreases waste

Benefits health provider and consumer

So how do we do it?

DE-PRESCRIBING GUIDELINES

Evidence shows de-prescribing is based on clinical experience and judgement rather than evidence (Thompson & Farrell 2013)

Current evidence
- Older adult
  - Beers criteria
  - Pill pruner
  - Prescribing optimizing method (POM)
  - STOPP/START
  - STRIP
  - www.deprescribing.org
  - Not specific, vaild, and adaptable enough for pallaitive care

DE-PRESCRIBING GUIDELINES

Palliative Care
- little guidance available
- inappropriate medicines and polypharmacy are common

Non-Malignant Diagnoses (End stage renal disease and heart failure)
- Palliative Care Formulary
- not transferable to oncology population

Malignant Diagnoses
- OncPal

ONC PAL - RATIONALE

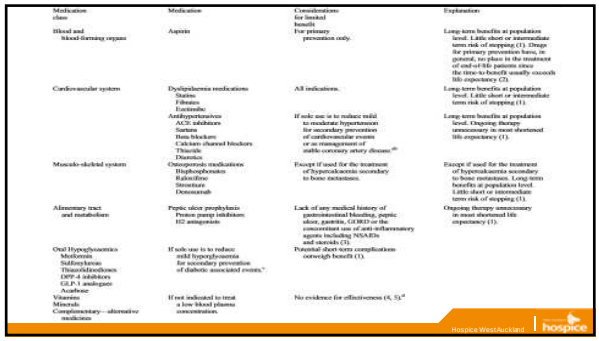
Malignant diagnoses still account for the majority of Hospice care

Transition from curative to palliative care
- may remain on medications with potentially harmful effects, or no short term benefit
- continue to be prescribed numerous medications for secondary prevention of co-morbid disease

De-prescribing in palliative care is poorly established compared with the older adult setting
- warrants further investigation

ONC PAL TOOL

- Specifically for de-prescribing within the oncological palliative care setting
- Provides a list of medications to guide de-prescribing and the rationale behind this
- Most suitable tool for the purpose of this audit



Medication class	Medication	Considerations for limited benefit	Explanation
Blood and blood-forming organs	Aspirin	For primary prevention only.	Long-term benefits at population level. Little short or intermediate term risk of stopping (1). Drugs for primary prevention have, in general, no place in the treatment of end-of-life patients since the time-to-benefit usually exceeds life expectancy (2).
Cardiovascular system	Dyslipidaemia medications Statins Fibrates Ezetimibe	All indications.	Long-term benefits at population level. Little short or intermediate term risk of stopping (1).
	Antihypertensives ACE inhibitors Sartans Beta blockers Calcium channel blockers Thiazide Diuretics	If sole use is to reduce mild to moderate hypertension for secondary prevention of cardiovascular events or as management of stable coronary artery disease.[4b]	Long-term benefits at population level. Ongoing therapy unnecessary in most shortened life expectancy (1).
Musculo-skeletal system	Osteoporosis medications Bisphosphonates Raloxifene Strontium Denosumab	Except if used for the treatment of hypercalcaemia secondary to bone metastases.	Except if used for the treatment of hypercalcaemia secondary to bone metastases. Long-term benefits at population level. Little short or intermediate term risk of stopping (1).
Alimentary tract and metabolism	Peptic ulcer prophylaxis Proton pump inhibitors H2 antagonists	Lack of any medical history of gastrointestinal bleeding, peptic ulcer, gastritis, GORD or the concomitant use of anti-inflammatory agents including NSAIDs and steroids (3).	Ongoing therapy unnecessary in most shortened life expectancy (1).
Oral Hypoglycaemics Metformin Sulfonylureas Thiazolidinediones DPP-4 inhibitors GLP-1 analogues Acarbose	If sole use is to reduce mild hyperglycaemia for secondary prevention of diabetic associated events.[5]	Potential short-term complications outweigh benefit (1).	
Vitamins Minerals Complementary—alternative medicines	If not indicated to treat a low blood plasma concentration.	No evidence for effectiveness (4, 5).[4]	

CLINICAL AUDIT

Why choose de-prescribing?

Team discussion
- topic
- practical and applicable to clinical setting
- ensures current evidence is incorporated into practice
- positively impacts on patients and their quality of life e.g. by reducing pill burden

CLINICAL AUDIT

Why choose de-prescribing?

Benefits to both health provider and consumer

Current practice
- room for improvement

LITERATURE REVIEW

Search

AUT library

CINAHL Database (Nursing and Allied Health Literature)

- De-prescribing
- Managing polypharmacy

LITERATURE REVIEW

Common themes

1. Adverse events
   - falls
   - drug interactions and reactions
2. Potentially inappropriate medicines (PIMs)
3. Patient - centered care
   - compliance
   - pill burden

LITERATURE REVIEW

Key points

1. Polypharmacy is higher in the palliative care setting compared with the non-palliative setting (McNeil, 2016)
2. The impact of taking multiple medication, particularly at end of life is significant (Connor, et al., 2015)

These findings underpin the rationale for this audit

- explore pill burden further

ST ANN'S HOSPICE MANCHESTER (2015)

27 bed hospice

Data collection over 1 month

140 patients total, 65 excluded *n=75*

Assessing

- level of satisfaction with medication
- reasons why they were not satisfied

Connors, K., Pickard, J., Phippen, A., Colding, J., Roberts, D., & Kay, S. (2016). Polypharmacy in an inpatient hospice setting - exploring the patients' views. *European Journal of Palliative Care, 23*(3), 125-127. Retrieved from http://www.ejpc.eu.com

ST ANN'S HOSPICE - FINDINGS

- Polypharmacy increases as patients approach end of life
  - symptom management
- Medication burden adversely affects quality of life
  - 12% reported medication interfering with their day
- Despite a overall high level of satisfaction with their medication 87% of patients indicated they would like to take fewer medicines
- Change to practice
  - patient leaflet – "Are you taking a lot of medicines?"

Connors, K., Pickard, J., Phippen, A., Colding, J., Roberts, D., & Kay, S. (2016). Polypharmacy in an inpatient hospice setting - exploring the patients' views. *European Journal of Palliative Care, 23*(3), 125-127. Retrieved from http://www.ejpc.eu.com

CLINICAL AUDIT

Aim

- Reduce polypharmacy and pill burden thereby improving the quality of life of patients who are receiving specialist palliative care

Guidelines Medical Council New Zealand recognises best practice to periodically review

- effectiveness of medications
- new information about the patient's condition
- continuation or modification of treatment should depend on an evaluation of progress towards treatment plan/goal

CLINICAL AUDIT - STANDARD

All patients admitted to HWA community service will have medications reviewed by their primary nurse

1. Admission to service
2. Following any significant events, such as admission to hospital or a deterioration of performance status
3. Re-screening to take place every three months (as a minimum)
4. Review medication at IDT

Primary Nurse responsibilities

- Liaise with the general practitioner in regards to any medication changes
- Clearly document discussion in e-clinical notes (Palcare)
- Update medication chart

CLINICAL AUDIT

Cases for audit Patients with a malignant diagnosis, enrolled to service within the community setting at Hospice West Auckland

- First cycle of audit
- More experience and familiarity
- My area of clinical practice

Audit tool OncPal and BPAC "Monitoring Polypharmacy and Reducing Problematic Prescribing"

Sampling All patients with a malignant diagnosis, admitted to service during 1st February 2016 and 30th April 2016 *n= 93*

- Palcare
- Hospital discharge summaries
- Community dispensing

PARAMETERS

BPAC Audit tool

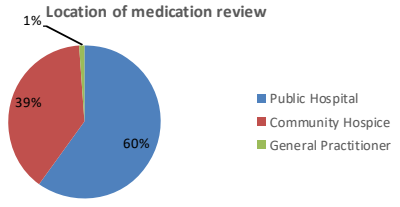
- ≥10 medications
- Evidence in the patient's record of a medicine review in the last 12 months?
- If no evidence, have they been flagged for future review?

Adaption of tool

- All patients, despite number of medication
  - focus on futility and burden
- Setting where review took place
- Patients condition at time of review
- Were medications prescribed that fit OncPal tool for de-prescribing

BPAC NZ. (2014). Polypharmacy in primary care: Managing a clinical conundrum. *Best Practice Journal, 64*. Retrieved from http://www.bpac.org.nz/BPJ/2014/October/polypharmacy.aspx

AUDIT FINDINGS



AUDIT FINDINGS

- 71% of patients were taking 5 or more medications (polypharmacy)
- Despite having medication review 28% remained on medication deemed futile (as per OncPal)
- 21% of patients that had not received a medication review were prescribed medication that would have been appropriate to discontinue (as per OncPal)
- 57% of de-prescribing occurred in the 2 months prior to death
- All Community Hospice-led de-prescribing took place when patient entered the last days of life

ISSUES IDENTIFIED

- Poor documentation of medication reviews and de-prescribing
  - Clear documentation is vital
    - Record keeping
    - Communication with colleagues
    - Impairs data collection

ISSUES IDENTIFIED

- Absence of formal process at HWA to prompt and guide medication reviews
  - Directly links to audit findings of Hospice de-prescribing at end of life
- Limited evidence-based practice on de-prescribing in palliative care
  - Challenges of studying an actively dying population
  - Highlighting the need for ongoing audits and research

DISCUSSION

Potential for unintentional bias
- Lengthy data collection
- Data collected across 3 hospitals, 2 DHBs, 1 Hospice and several GPs
- Relied on accuracy of documentation of many
- Were more cases reviewed but not documented?

71% of patients were taking 5 or more medications
- significant polypharmacy
- reflects current evidence

DISCUSSION

28% of patients that had received a medication review remained on medication deemed futile within the palliative care setting (as per OncPal)
- Rationale unclear/poorly documented

Potential factors
- Performance status
- Patients resisting/refusing
  - spiritual, religious and/or cultural beliefs
- Medication reviewer not perceiving the medication to be futile
  - lack of evidence-based practice

DISCUSSION

Why was the hospital setting completing the most reviews?

- Formal process/guideline in place
- Access to medical team and pharmacist
- Perception/Acceptance of de-prescribing in this setting
- Potentially less communication/different approach to communication

DISCUSSION

57% of de-prescribing occurred in the 2 months prior to death and all community Hospice-led de-prescribing took place when patient entered the last days of life

- Are we acutally de-prescribing?
  - lead by switching medication to the subcutaneous route
- Earlier intervention to improve quality of life

RECOMENDED ACTIONS

- Guideline for de-prescribing
  - including a hierarchy of medications
- Education on de-prescribing and the use of OncPal
  - ongoing
- Incorporate recording of medication review/de-prescribing into IDT meetings
  - flag need for future review
- Standardised care plan for documenting medication review and de-prescribing
- Re-audit in 6 months then yearly
- Collaboration/liaison other Hospices

CONCLUSION

- The importance of audit/research in Palliative Care
- Acknowledge and use tools available
  - OncPal
- De-prescribing – not just a buzz word
  - clinical need
  - clinical impact
  - response to patient – centred care
  - requires a pro-active and vigilant approach

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HOW DO YOU MANAGE THIS IN YOUR AREA?

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