Prescribing Recommendations

1. Medication Review Framework

See www.patient-partnership.org for medication review tools

A thorough patient assessment is an essential part of the medication review process. The most complete review will involve both the patient's notes and a discussion with the patient. It is possible to make a documentary review from looking at the records alone. One major disadvantage in not talking to the patient is that you will not find out if they have any problems that stop them taking the medicine and whether they have any questions or concerns. In addition negotiating change with the patient is an essential part of the review. The following framework lays out the steps involved in a clinical medication review – Level 3.

- **Invitation**
  Consider who needs to be invited in for review. This should ideally be defined in the local strategy for implementing medication reviews (See Section 5 of the Guide: Putting medication review into practice), which should identify categories of patient to prioritise for review.

  Two tools have been prepared to help you invite patients for review;
  - Patient information sheets
  - Invitation letters

- **Preparation**
  It is important to allow 10 minutes to scan notes/computer prior to seeing the patient, particularly for the patient's first review. Practices who are using their computer to full advantage will record different aspect of the patient's conditions under different "problem" titles. It is essential that you can navigate your way round the computer to find all the relevant information. A training session is time well spent. Review of the patient's record will give an opportunity to familiarize yourself with the patient's medical history and begin to link up the medicine with the diagnoses. In this process you may discover anomalies that you will need to ask the patient about. Some practices will have a summary of the notes that will make this stage quicker. However, this is likely to be variable and it is

important to make allowances for this in the time you calculate you will need to do the initial review. If you do not have notes summarized you then you will have to do your own. A good starting place is to go through the hospital letters. This will give you a baseline from which to work. Also if you trace back to when the medicine was originally prescribed it should give you a starting point. The documentation of diagnosis and resultant prescribing can vary widely. Often it will be up to you do some detective work. The gold standard is the "linked diagnosis", where each medicine is electronically linked to an indication. This is currently only possible on some computer systems.

When you have completed this stage you should be able to link up the medicine to the diagnoses. If this is not possible then you will have to discuss the discrepancies with the patient. The medicine may have been prescribed for a legitimate reason but this might not have been recorded.

The following supporting tools have been prepared to help you;

- Areas to cover in a medication review - Sources of information
- Areas to cover in a medication review - Options for intervention

- **Patient Consultation**
  The consultation has a number of purposes;

  - To establish that the medicines being taken by the patient are the best for their needs.
  - To evaluate the effectiveness of the medicine from the patient's point of view.
  - To identify reasons why medicines are not taken or taken incorrectly.
  - To answer patients' questions on the medicines and their illness.
  - To identify untreated illness.
  - To reach agreement about continuing or changing treatment.

  It is important firstly to establish a relationship with the patient. This will involve listening to what they have to say. The most important aspect is that you have a structure to the discussion so that you make sure that you cover all the areas. This will also enable you to make sure that listening carefully to the patient and covering what is important to them doesn't prevent the primary purpose of the discussion being achieved.

This toolkit contains a medicines reminder chart to help patients remember when to take regular prescribed medicines. It is designed to be completed with the patient during the review.

- **Implementation**
  Changes should only be implemented after discussion with the patient and, if applicable, the GP. The patient should be advised when any changes in treatment will come into effect e.g. immediately or when the next repeat prescription is due. The patient should be provided with a written copy of the new repeat prescription regimen e.g. a copy of the right hand side of the FP10.The patient should also be advised if further follow up will necessary e.g. a blood test.

- **Recording**
  Changes to the medicine regimen should be made on the computer and, if applicable, the list of current medicines in the front of the Lloyd George notes. A new review date should be set or the number of authorised issues reset. This should usually be no greater than 1 year but may be shorter if necessary.

  Ideally details of the medication review should be recorded electronically under a Read code such as 8B3V "medication review done". Using a Read code will make subsequent audit easier.

- **Follow-up**
  Any recommendations or changes made should be followed up after a suitable period of time to check if they have been implemented. The outcome of changes also need follow up. If necessary the patient may need to re-attend to discuss the outcomes and any further alterations in the regimen that are necessary

2. Reviewing repeat prescriptions for PPIs

- If 55 or over with recent development of dyspepsia consider referral for endoscopy.
- Patients with a confirmed DU or PU but no confirmation of *H Pylori* status should have *H Pylori* eradication treatment.

- Patients who have the following will probably have to have treatment left alone;
  - grade 3 or 4 GORD
  - Zollinger Ellison Syndrome
  - Barretts' Oesophagitis
  - Under specialist supervision
  - Recent GI bleed
  - Previous trial on maintenance dose

- Patients taking NSAID and with PPI cover;Can a change be made to simple analgesia?

- Watch out for co-prescribing of misoprostol/diclofenac (Arthrotec) and a PPI/H2 antagonist. There is usually no need for both.

- All other patients on treatment doses should be considered for a trial of maintenance dose treatment.

6. Falls in the elderly

When reviewing elderly patients consider;

1. **Drugs that might contribute to falls**

    - Drugs causing sedation – e.g. benzodiazepines, sedating antihistamines, tricyclic antidepressants.
    - Drugs causing hypotension – e.g. diuretics, beta blockers, ACE-I, alpha blockers, calcium channel blockers and vasodilators. Psychiatric drugs e.g. chlorpromazine and risperidone. Parkinsonium drugs

2. **Prophylaxis that might help in preventing fractures**

    The elderly, previous fractures, known osteoporosis, oral steroid treatment (>7.5mg/day), poor diet and lack of sunlight for example all contribute to fractures.

    For ask risk groups prescribe Calcium and Vitamin D as Adcal D3 or Calcichew D3 two daily.

3. **Other factors that might contribute to falls**

    Consider other factors such as social circumstances, alcoholism, loose carpets, lack of hand rails etc.