IMPERIAL COLLEGE HEALTH PARTNERS

Fiendish Cases

Learning from Real Life Polypharmacy

Medicines Optimisation Case Studies

Dr Graham Stretch

Agenda

Agenda Item	Speaker	Time (mins)
Welcome & Housekeeping	**Cat Caldwell,** Imperial College Health Partners	5
Setting The Scene	**Dr Graham Stretch,** PCPA President Partner Argyle GP Lead Pharmacist Ealing Community Partners	5
Approach to Polypharmacy and Deprescribing		15-20
Case 1: High-Risk Medicines		15-20
Case 2: Polypharmacy in Advanced Age		15-20
Case 3: Dysphagia and Covert Administration		15-20
Case 4: Acute on Polypharmacy		15-20
Open Discussion and Q&A		15-20
Feedback and Close	Cat Caldwell	5

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Welcome & Housekeeping

- Please remain on mute and with camera off unless speaking
- Please maintain confidentiality as appropriate
- Questions? Enter into the chat, or, during our Q&A section at 13:45 use ‘raise hand’ function
- Please note we will be recording this meeting, the slides will be shared after the session

Polypharmacy:

getting the balance right

Multiple Dates Available

Learn how the NHS BSA polypharmacy prescribing comparators help us understand variation in prescribing of multiple medicines and identify patients more likely to be exposed to the risk of taking multiple or combinations of medicines.

Book your place:

HERE

Health Innovation Network

NHS Business Services Authority

Polypharmacy ALS

The HIN polypharmacy programme has recently released final dates for the Action Learning Sets (ALS) to help build GP and prescribing health care professionals confidence in, and understanding of, the complex issues surrounding stopping inappropriate medicines safely. Delegates need to attend all three sessions.

The ALS will also help PCNs deliver the medicines optimisation elements of the new Directed Enhanced Services contract and contributes to QoF.

Cohort 23

23rd April 7th May and 21st May

Polypharmacy Action Learning Set Cohort 23

National Polypharmacy Masterclasses

Polypharmacy and Parkinson's Lunchtime Masterclass

12th March 12pm to 1.30pm

Join to hear from Parkinson specialists about problematic polypharmacy in people with Parkinson's Disease. Increase your understanding of Parkinson's Disease and how to improve prescribing for this group of patients.

What will be covered?

- Parkinson's disease, the basics.
- Parkinson's and Polypharmacy - red flag medicines, medicines to think about carefully, when specialists need to be involved.
- Parkinson's in care home patients.
- Case study learning.

Our Guest Speakers are Karen Kite, Lead Clinical Pharmacist at Solihull Rural PCN and Dr Robin Fackrell, Consultant Physician & Specialist in Parkinson's Disease and related disorders at Royal United Hospitals

NHS Foundation Trust.

Click here to register

Polypharmacy and Learning Disabilities Lunchtime Masterclass

20th March 12pm to 1.30pm

People with a learning disability die 20 years younger than others and are often given multiple medications, including being 16 times more likely to be prescribed psychotropic medications. Stopping over medication of people with a learning disability and autistic people (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP) are everyone's business, and this masterclass will focus on your role in supporting with structured, holistic and person-centred medication reviews.

Our Guest Speakers are; Dave Gerrard, Health Improvement Pharmacy lead, Learning Disability and Autism, NHS England; Carl Shaw, Learning Disability and Autism Adviser, NHS England; and Alisa Watson, Expert by Experience Co-worker, Health Improvement Team, NHS England and NHS Improvement.

Click here to register

Polypharmacy Pillar 3

A public-facing campaign to change people's perception of a 'pill for every ill' and encourage patients to open up about their medicines

'Are your medicines working for you' is a campaign designed to support more open conversations between patients and healthcare professionals about whether or not long-term medicines should continue to be prescribed. This will help everyone benefit from more effective and safer care.

Families and carers **are encouraged to ask questions about their medicines** so that they can be helped to get the most benefit. Everyone helping the patient's experience of the NHS, including Community Pharmacy, GPs, Hospital Doctors, Nurses and Hospital Pharmacy are being encouraged to listen to, better understand, and help overcome problems when using medicines.

Polypharmacy patient behavior change campaign

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When	**September 2024 to March 2025**
What is ICHP doing	▪ Patient materials hosted online by ICHP ▪ Acura template with link to patient materials supplied by ICHP to encourage attendance of Structured Medication Reviews (SMR) ▪ Post campaign analysis
What are we asking of PCNs	▪ Invite patients to SMRs are per business as usual (BAU) ▪ Use AccuRx template with embedded link to ICHP patient materials ▪ Perform SMRs as per business as usual ▪ Send follow up AccuRx with embedded ICHP survey ▪ Clinician survey to be completed at 0 months, 3 months & 6 months ▪ To provide aggregate data on SMR invitees & attendees
What do the PCNs get in return	▪ Improved engagement in SMRs ▪ ICHP support through provision of patient materials including hosting of resources ▪ Data analysis evaluation of PCN SMRs for time period ▪ Report on patient campaign at local and national level
How will this be measured	▪ Measurement of click rates on patient materials ▪ SMR invitees & attendees ▪ SMR completion rates ▪ Clinician and patient feedback

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Fiendish cases - learning from real life polypharmacy – medicines optimisation case-based discussions

Dr Graham Stretch,
PCPA President
Partner Argyle GP
Lead Pharmacist Ealing Community Partners

Setting the Scene

Setting the Scene

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Key points:

- A structured approach to reviewing frailty
- Tools and resources to use at base
- Real case discussions for peer to peer learning

PCPA

Pharmacokinetics

↓PB, ↓Metabolism,
↓Clearance, ↓Elimination,
↓BBB

Bone Health= Osteoporosis

GI motility = Constipation

Orthostatic circulatory responses

Blunting of reflex tachycardia=postural hypotension, On rising from rest, BP should increase doesn't = postural hypotension = **FALLS**

Prostatic hypertrophy, OAB, urethral dysfunction = Incontinence

Cognitive function

change in CNS = confusion

Pharmacodynamics

↑Sensitivity, ↑Response,
↓Compensation

Postural control

- ↓ in dopamine receptors in stratum
- ↓ Static postural reflexes

↑ **FALLS**/fractures

1. **Immobility**
2. **Instability**
3. **Incontinence**
4. **Intellect**

The giants of geriatrics are immobility, instability, incontinence and intellectual impairment. They have in common multiple causation, chronic course, deprivation of independence and no simple cure.

— Bernard Isaacs, The Challenge of Geriatric Medicine, Oxford University Press, 1997

CLINICAL FRAILTY SCALE

1 **VERY FIT** — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 **FIT** — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

3 **MANAGING WELL** — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 **LIVING WITH VERY MILD FRAILTY** — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.

5 **LIVING WITH MILD FRAILTY** — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 **LIVING WITH MODERATE FRAILTY** — People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **LIVING WITH SEVERE FRAILTY** — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 **LIVING WITH VERY SEVERE FRAILTY** — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 **TERMINALLY ILL** — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

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PCPA

European Ge
https://doi.o

RESEAR

STOPP
people

Denis O'M
Graziano
Nathalie v

Received: 10

Key summ
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Findings
geriatric p
expansion
Message
prescribin
review in

Appendix 1

Screening Tool of Older Persons' Prescriptions (STOPP) version 3.

The following prescriptions are potentially inappropriate to use in patients aged 65 years and older.

lder

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iat[11] ·

inel of experts in
ia), reflecting the
ition of version 2.
ions and potential
luring medication

Section A: Indication of medication

1. Any drug prescribed without a clinical indication.

2. Any drug prescribed beyond the recommended duration, where treatment duration is well defined.

3. Any duplicate drug class prescription for daily regular use (as distinct from PRN use) e.g., two concurrent NSAIDs, SSRIs, loop diuretics, ACE inhibitors, anticoagulants, antipsychotics, opioid analgesics (optimisation of monotherapy within a single drug class should be observed prior to considering a new agent).

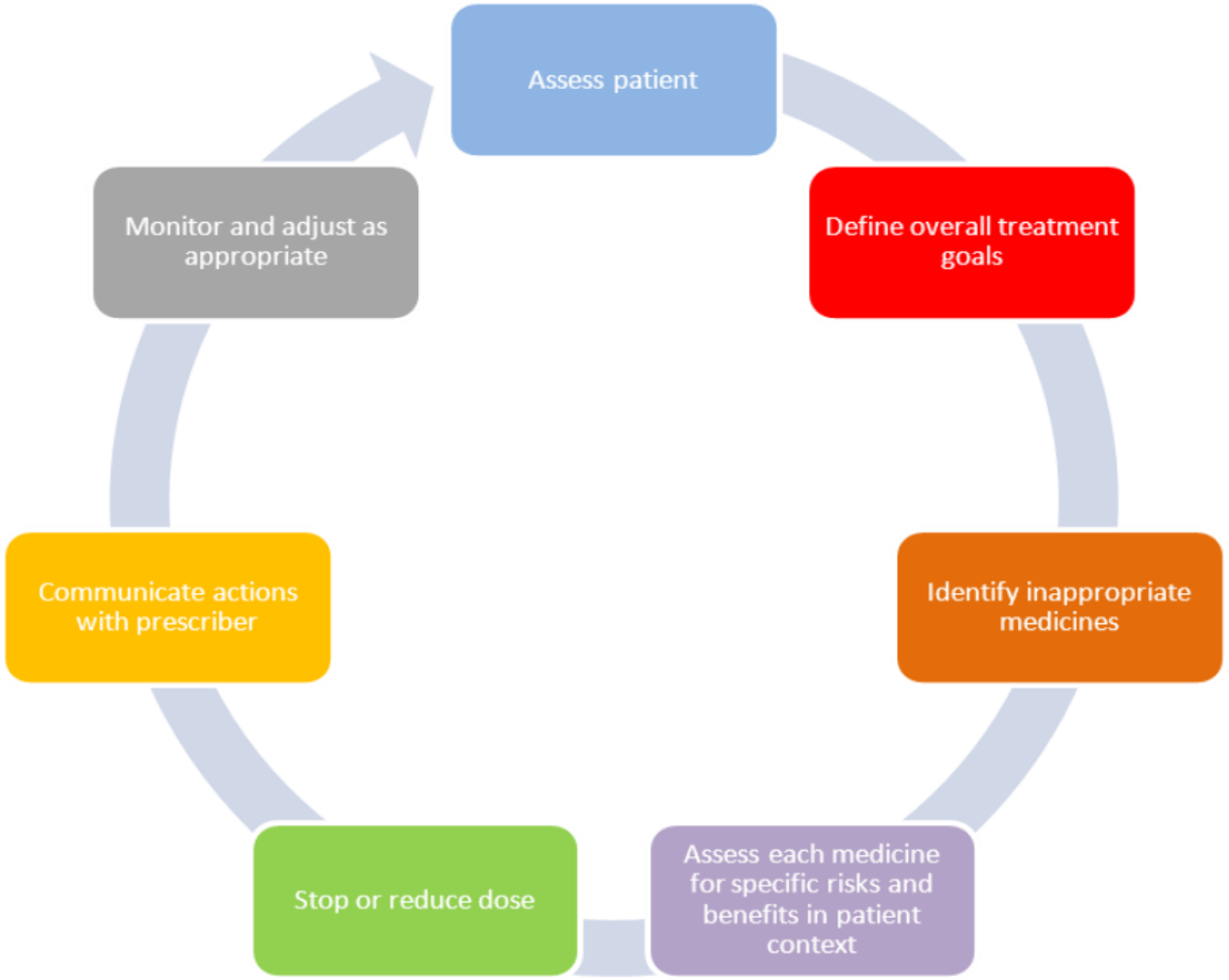
Section B: Cardiovascular System

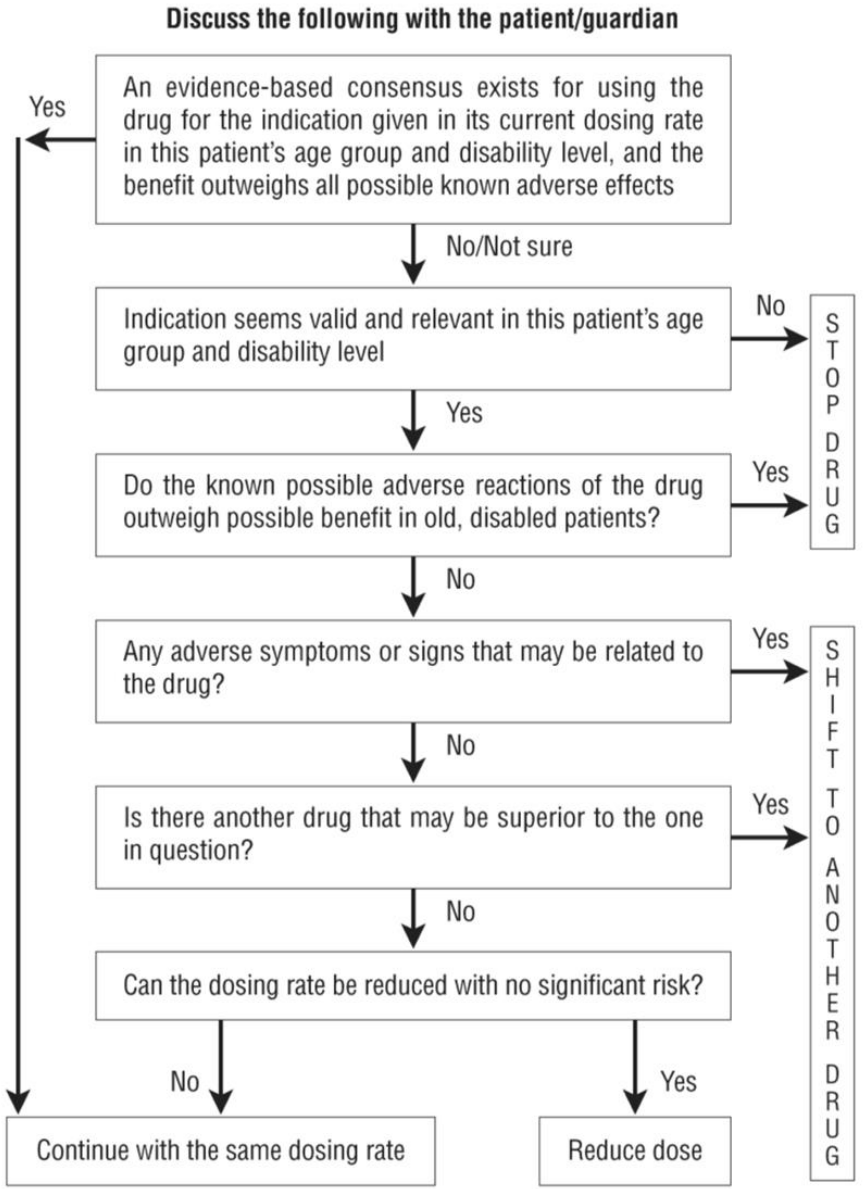
1. Digoxin for heart failure with normal systolic ventricular function (no clear evidence of benefit)

2. Verapamil or diltiazem with NYHA Class III or IV heart failure (may worsen heart failure with reduced ejection fraction i.e., HFREF).

3. Beta-blocker in combination with verapamil or diltiazem (risk of heart block).

4. Ventricular rate-limiting drugs i.e., beta blocker, verapamil, diltiazem, digoxin with

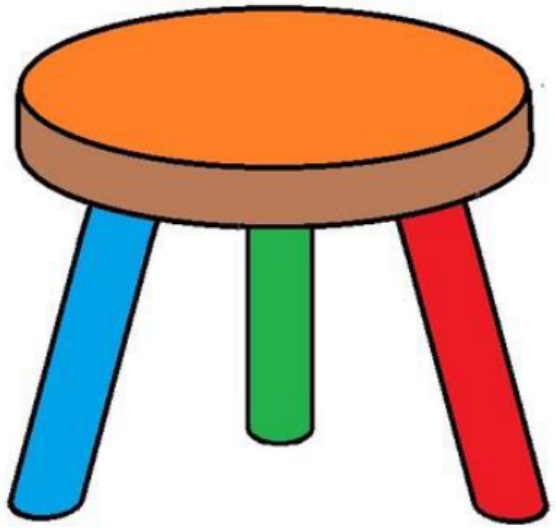




Gafinkel *et al. Arch Intern Med.* 2010;170(18):1648–1654

Lelly Oboh & Nina Barnett, SPS

Integrating best research evidence with clinical expertise and patient values *(Sackett et al. BMJ 1996)*



- ✓ Best available research evidence
- ✓ Clinical judgement of the practitioner

- ✓ Patient's circumstances, **goals**, **values** & wishes

Lelly Oboh & Nina Barnett, SPS

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Case 1: High-Risk Medicines

Colin Janes

PC

- 80yo man with complex polypharmacy and multiple co-morbidities
- He is back from Thailand last week.
- Booked in for routine SMR but is complaining of ‘Bruised’ ‘Blue Face’ and too many pills.
- Wants you to ‘do something for him’ – you have bloods arranged in advance.

Janes, Colin (Mr)

Janes, Colin (Mr)		**NHS Number: 123456789**	
09 Apr 1946 00:00 (80 y)	Gender	Male	

Contact Details

Current Home Address	12 The Lane, Ealing, W13	19 Jun 2012 -
Mobile Tel.	07973123456	

Registration Details

Usual GP	GOOD, Doris (Dr)	Home GP
Usual Branch	The Argyle Surgery (02080901153)	

Active Problems

Herpes zoster NOS (A53z.)	**30 Jun 2012 - Ongoing**
Short Note	**has had 5 years ago , now clear with no residua...**
Pure hypercholesterolaemia (XE11S)	**2013 - Ongoing**
Depressive disorder (X00SO)	**2013 - Ongoing**
Erectile dysfunction (E2273)	**2014 - Ongoing**
Hypertension (XE0Ub)	**2014 - Ongoing**
Ischaemic heart disease (XE2uV)	**2015 - Ongoing**
Moderate learning disability (XaQZ3)	**24 Nov 2016 - Ongoing**
Feeling anxious (XE0rb)	**14 Jun 2017 - Ongoing**
Short Note	**feeling generally anxious. worried about bully...**
Asthma (H33..)	**21 Aug 2017 - Ongoing**
Type II diabetes mellitus (X40J5)	**25 Jul 2019 - Ongoing**
Atrial fibrillation (G5730)	**16 Jul 2021 – Ongoing**
Diabetic neuropathy (X00Ag)	**12 Jan 2022 – Ongoing**
Blue skin (Xa9su)	**12 Feb 2025 - Ongoing**

Current repeat templates

09 Mar 2022	Senna 7.5mg tablets	Take 2 tablets TWICE a day	60 tablet	05 Jul 2024
28 Jan 2025	Bisoprolol 1.25mg tablets	Take One Daily	28 tablet	05 Jul 2024
28 Jan 2025	Amiodarone 200mg tablets	take one daily	28 tablet	05 Jul 2024
28 Jan 2025	Edoxaban 60mg tablets	Take ONE tablet daily to thin blood	28 tablet	05 Jul 2024
28 Jan 2025	Gabapentin 400mg capsules	take one 3 times/day	90 capsule	05 Jul 2024
28 Jan 2025	Paracetamol 500mg tablets	Take ONE or TWO tablets, QDS PRN	100 tablet	05 Jul 2024
28 Jan 2025	Amlodipine 10mg tablets	Take ONE tablet daily for blood pressure	28 tablet	05 Jul 2024
28 Jan 2025	Citalopram 40mg tablets	Take ONE tablet daily for mood	28 tablet	05 Jul 2024
28 Jan 2025	Furosemide 40mg tablets	take one each morning for ankle swelling	28 tablet	05 Jul 2024
28 Jan 2025	Gliclazide 30mg modified-release tablets	1 to be taken morning and evening	56 tablet	05 Jul 2024
28 Jan 2025	Isosorbide mononitrate 60mg modified-release tablets	1 To be taken Twice Daily	56 tablet	05 Jul 2024
28 Jan 2025	Metformin 500mg tablets	take one 3 times/day	84 tablet	05 Jul 2024
28 Jan 2025	Salbutamol 100micrograms/dose inhaler CFC free	ASTHMA: Inhale TWO PUFFS slow and steady, when required.	200 dose	05 Jul 2024
28 Jan 2025	Sildenafil 50mg tablets	Take ONE as directed	8 tablet	05 Jul 2024
28 Jan 2025	Simvastatin 40mg tablets	Take ONE tablet at night	28 tablet	05 Jul 2024
28 Jan 2025	Tramadol 50mg capsules	take 1 or 2 every 4-6 hrs	100 caps	05 Jul 2024

Journal

12 February 2025 14:26	Surgery: STRETCH, Graham (Dr) (Pharmacist)

Pulse rate (X773s) 56 bpm irregular, irregular Blue skin (Xa9su)

Estimated creatinine clearance (Cockcroft-Gault formula) (Xaccy) 44.63 mL/min

162 / 93 mmHg O/E - height (229..) 1.63 m (5 ' 4 ")

O/E - weight (22A..) 94 Kg (14 st 11 lb) Body mass index - observation (22K..) 35.38 Kg/m²

Hx – Patient presents with 1/52 history of ‘blue face’ after Thai holiday very anxious – wanted to know ‘what can we do about it’ as it is embarrassing.

O/E – NAD fever, Chest (mild wheeze), NAD Lymph, bowels normal, weight stable. No change in exercise tolerance. Denies nausea, chest pain

Latest blood tests

Biochemistry Overview		
Clinical Chemistry (LBP & UE) Overview		
Plasma creatinine level	**156 umol/L**	**23 Jan 2025**
Plasma albumin level	**38 g/L**	**23 Jan 2025**
Plasma globulin level	**2 g/L**	**23 Jan 2025**
HbA1c level (diagnostic reference range) - IFCC standardised	**69.4 mmol/mol**	**23 Jan 2025**
Biochemistry Overview		
Serum cholesterol level	**7.2 mmol/L**	**23 Jan 2025**
Calculated LDL cholesterol level	**5.6 mmol/L**	**23 Jan 2025**
Plasma albumin level	**38 g/L**	**23 Jan 2025**
Plasma globulin level	**2 g/L**	**23 Jan 2025**
Brain natriuretic peptide level	**547 pmol/L**	**23 Jan 2025**
HbA1c level (diagnostic reference range) - IFCC standardised	**69.4 mmol/mol**	**23 Jan 2025**

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Case 2: Polypharmacy in Advanced Age


Lucy

RESIDENT, Lucy (Ms)
Patient Summary: Home Visit Summary.

RESIDENT, Lucy (Ms) **NHS Number: 123 4567 8910**

Date of Birth 02 Feb 1943 00:00 (79 y) Gender Female

Contact Details

Current Home Address LD Home, Ealing 27 Oct 1991 -

Registration Details

17 Jul 2019	Housebound (13CA.)		

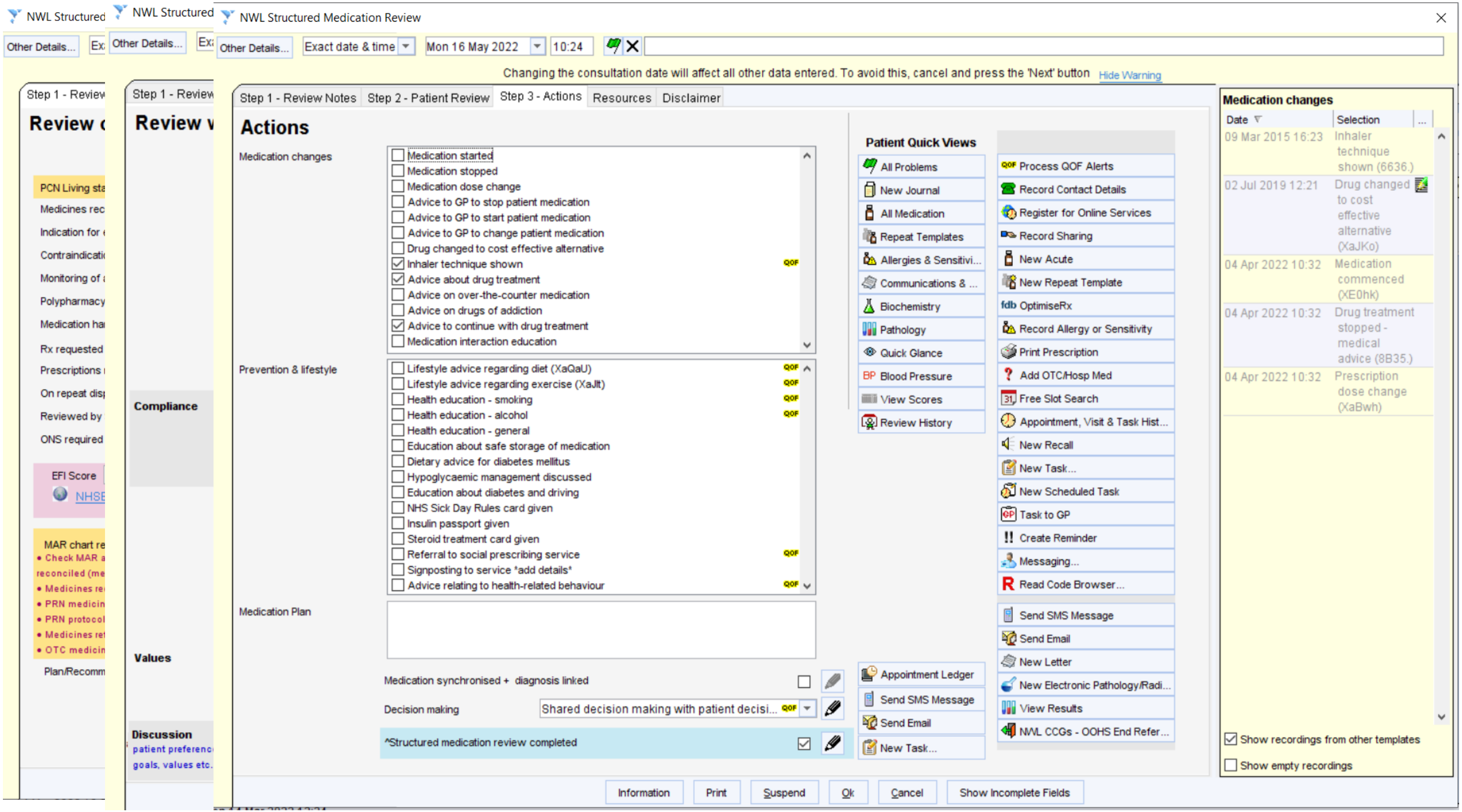
Summary History

Learning difficulties (13Z4E)	1955 - Ongoing
Asthma (H33..)	2002 - Ongoing
Epilepsy (F25..)	15 Jan 2002 - Ongoing
Severe learning disability (XaQZ4)	01 Jun 2015 - Ongoing
Frailty (Xabdb)	06 Apr 2016 - Ongoing
Impaired cognition (Ua189)	May 2017 - Ongoing
Impaired fasting glycaemia (XaIRY)	24 May 2017 - Ongoing
Atrial fibrillation (G5730)	10 Feb 2021 - Ongoing
Sepsis (X70VZ)	24 May 2021 - Ongoing
Chronic type 2 respiratory failure (XaO5m)	2022 - Ongoing
Dysphagia (XM08J)	29 Mar 2022 - Ongoing

02 May 2022 12:00	Green Lane, Use for other contact location please specify: xxx, xxx (Health Professional Access Role) Entered at: Ealing Learning Disabilities	Entered: 02 May 2022 14:08
	Community clinic note (XaIkM) SLT - Planned video swallow review rescheduled T/c to xxx at 11:40am, spoke with xxx who was not aware of 12pm assessment today. He said Lucy was sleeping - agreed to start assessment at 12:30pm instead and to trial sandwiches as well as Level 6 diet option (Salmon) Connected to MS Teams - Lucy observed to be sleeping in her wheelchair. xxxx attempted to rouse her - she took a drink of tea (from beaker with spout and no handles) and brought this to her mouth, but did not take any fluid + eyes were closing. She was observed to chew with no food in her mouth. xxxx said in this situation they would try again in 30 minutes - agreed to try again at 1pm. Connected at 1pm - Lucy still sleeping in her wheelchair and unable to rouse, he said she was even more drowsy now. He advised on days like today she would not tolerate Level 6 diet and agreed not a good day to trial bread. Agreed to reschedule. xxxx reported Lucy has been managing really well with current SLT diet recommendations. Email sent to Managers xxxx and xxxx feeding back summary of above and offering future assessment dates over the next 2 weeks. SLT to await confirmation. Activity: Review (10 minutes) Video Call with Patient	
	Patient Contact: 10 minutes	Total Contact: 10 minutes

. Paracetamol 500mg effervescent tablets - 100 tablet - take 1 or 2 tablets 4 times/day When Required for pain/fever
(R) Apixaban 5mg tablets - 56 tablet - take one twice daily, in the morning and in the evening. The tablets can be crushed and dispersed in water, glucose 5%, apple juice, or apple puree
(R) Atorvastatin 20mg tablets - 28 tablet - take one daily. The tablets can be crushed and mixed with water for administration.
(R) Cavilon Durable barrier cream (3M Health Care Ltd) - 56 gram - Apply as barrier cream
(R) Clobazam 10mg tablets - 56 tablet - two at night. The tablets can be dispersed in water for administration. They disperse in one to five minutes.
(R) Colecalciferol 440unit / Calcium carbonate 1.25g effervescent granules sachets - 56 sachet - Take one sachet twice daily
(R) Diclofenac diethylammonium 1.16% gel - 200 gram - Apply to affected area when required for pain
(R) Digoxin 62.5microgram tablets - 28 tablet - take one daily. The tablets can be crushed for administration
(R) Epimax original cream (Aspire Pharma Ltd) - 1000 gram - Use as a soap substitute
(R) Lansoprazole 15mg orodispersible tablets - 28 tablet - Take ONE daily
(R) Phenytoin 30mg/5ml oral suspension - 1320 ml - Give 46.7ml (280mg) ONCE a day at 8am using a syringe
(R) Propranolol 10mg/5ml oral solution sugar free - 1050 ml - Take 10ml three times a day, morning afternoon and night
(R) Levetiracetam 100mg/ml oral solution sugar free - 300 ml - Take 7.5ml in the MORNING and 10ml in the EVENING

- **03 May 2022 03:12 Blood Sciences** **The Argyle Surgery Dr Graham Stretch**
- **Sample T#### (BLOOD)**
  Collected 02 May 2022 10:00
  Received 02 May 2022 12:24
- **FBC**
  - **WBC 6.6 10*9/L 4.2 - 11.2**
  - **RBC * 3.64 10*12/L 3.73 - 4.96**
  - **Haemoglobin 125 g/L 114 - 150**
  - **Haematocrit 0.383 L/L 0.350 - 0.450**
  - **MCV * 105.0 fL 83.5 - 99.5**
  - **MCH * 34.3 pg 27.5 - 33.1**
  - **MCHC 326 g/L 315 - 350**
  - **RDW 13.7 % 10.0 - 15.9**
  - **Platelets 283 10*9/L 135 - 400**
  - **MPV 8.4 fL 7.4 - 11.5**
  - **Nucleated RBC 0.0 10*9/L 0.0 - 0.1**
  - **Neutrophils 3.1 10*9/L 2.0 - 7.1**
  - **Lymphocytes 2.4 10*9/L 1.1 - 3.6**
  - **Monocytes 0.6 10*9/L 0.3 - 0.9**
  - **Eosinophils 0.3 10*9/L 0.0 - 0.5**
  - **Basophils 0.0 10*9/L 0.0 - 0.2**
  - **C-Reactive Protein * 6.0 mg/L 0.0 - 5.0**
- **LFT and BONE Profile**
  - **Alanine Transaminase <6 U/L 0 - 34**
  - **Alkaline Phosphatase 61 U/L 30 - 130**
  - **Bilirubin <5 umol/L 0 - 21**
  - **Calcium 2.40 mmol/L 2.20 - 2.60**
  - **Adjusted Calcium 2.56 mmol/L 2.20 - 2.60**
  - **Phosphate 1.12 mmol/L 0.80 - 1.50**
  - **Albumin * 28 g/L 35 - 50**
  - **Total Protein 70 g/L 60 - 80**
  - **Globulin * 42 g/L 19 - 35**
- **UE Profile**
  - **Sodium 140 mmol/L 133 - 146**
  - **Potassium 4.3 mmol/L 3.5 - 5.3**
  - **Chloride 102 mmol/L 95 - 108**
  - **Urea 6.5 mmol/L 2.5 - 7.8**
  - **Creatinine * 50 umol/L 55 - 110**
  - **Estimated GFR * 88 mL/min/1.73m2 >89**


NWL Structured Medication Review
Other Details...
Exact date & time
Mon 16 May 2022
10:24
Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button
Hide Warning
Step 1 - Review Notes
Step 2 - Patient Review
Step 3 - Actions
Resources
Disclaimer
Actions
Medication changes
Medication started
Medication stopped
Medication dose change
Advice to GP to stop patient medication
Advice to GP to start patient medication
Advice to GP to change patient medication
Drug changed to cost effective alternative
Inhaler technique shown
Advice about drug treatment
Advice on over-the-counter medication
Advice on drugs of addiction
Advice to continue with drug treatment
Medication interaction education
Prevention & lifestyle
Lifestyle advice regarding diet (XaQaU)
Lifestyle advice regarding exercise (XaJlt)
Health education - smoking
Health education - alcohol
Health education - general
Education about safe storage of medication
Dietary advice for diabetes mellitus
Hypoglycaemic management discussed
Education about diabetes and driving
NHS Sick Day Rules card given
Insulin passport given
Steroid treatment card given
Referral to social prescribing service
Signposting to service *add details*
Advice relating to health-related behaviour
Medication Plan
Medication synchronised + diagnosis linked
Decision making
Shared decision making with patient decisi...
^Structured medication review completed
Patient Quick Views
All Problems
New Journal
All Medication
Repeat Templates
Allergies & Sensitivi...
Communications & ...
Biochemistry
Pathology
Quick Glance
Blood Pressure
View Scores
Review History
Process QOF Alerts
Record Contact Details
Register for Online Services
Record Sharing
New Acute
New Repeat Template
OptimiseRx
Record Allergy or Sensitivity
Print Prescription
Add OTC/Hosp Med
Free Slot Search
Appointment, Visit & Task Hist...
New Recall
New Task...
New Scheduled Task
Task to GP
Create Reminder
Messaging...
Read Code Browser...
Send SMS Message
Send Email
New Letter
New Electronic Pathology/Radi...
View Results
NWL CCGs - OOHS End Refer...
Appointment Ledger
Send SMS Message
Send Email
New Task...
Medication changes
Date
Selection
09 Mar 2015 16:23
Inhaler technique shown (6636.)
02 Jul 2019 12:21
Drug changed to cost effective alternative (XaJKo)
04 Apr 2022 10:32
Medication commenced (XE0hk)
04 Apr 2022 10:32
Drug treatment stopped - medical advice (8B35.)
04 Apr 2022 10:32
Prescription dose change (XaBwh)
Show recordings from other templates
Show empty recordings
Information
Print
Suspend
Ok
Cancel
Show Incomplete Fields

16 May 2022 09:04	The Argyle Surgery, Surgery: xxxx, xxxx (Ms) (Pharmacist) Entered at: The Argyle Surgery
	Called to investigate contact from son and carers re concerns of drowsiness – SMR performed in presence of xxxx & xxxxx (son). Son anxious as wonders if epilepsy worse, he hasn't seen her so 'out of it' before. -Can see was reviewed 25.06.21 in regards to propranolol as per Neuro, feels shaking/ movements have improved a little since starting propranolol as used to spill drinks and now is not. As per notes 25.06.21 due for neuro follow up to review all antiepileptics as well as propranolol, but for now to continue. -Confusion, agitation, eye rolling and jerks reported, ?Seizures? -Lucy has taken same meds for many years and tolerated well, not something that can be changed lightly, usually only under neuro advice as may alter seizure control. -Phenytoin, clobazam and levetiracetam could cause drowsiness- all of which have been tolerated well until now -Can have repeat bloods as due for DOAC monitoring. Also include ferritin, folate, vitamin b12 and vitamin D to check for vitamin deficiencies -discuss MDT later today Pathology Request (Request Sent): Vitamin B12 (e) (Requested), Full blood count (e) (Requested), Haemoglobin A1c (e) (Requested), Ferritin (e) (Requested), Liver Function Tests (Requested), Phenytoin level (Requested), Serum folate (e) (Requested), Thyroid stimulating hormone (Requested), UE - Urea & electrolytes (e) (Requested), Vitamin D (Requested)

16 May 2022 09:04 | The Argyle Surgery, Surgery: xxxx, xxxx (Ms) (Pharmacist) Entered at: The Argyle Surgery

NWL Structured Medication Review

Step 1 - Review Notes

Reviewed by SALT: Yes
Prescriptions requests appropriate : Yes
MAR chart reconciled: Yes
Monitoring of all medication checked: Yes
Medication harm risk assessment: Yes
Polypharmacy medication review: Yes
Indication for each drug checked: Yes
Medicines reconciliation checked and completed: Yes
PCN Living status codes: Lives in a residential home (XaImT)
Rx requested by: Nurse/Carer at Care Home

Step 2 - Patient Review

Parent / carer present at assessment (Y1517)
Discussion about treatment with carer (Xabgo)
Medication not taken - problem swallowing: Yes
Adherence : Partial adherence to medication regimen (XaZBU)
Formulation: Drug formulation appropriate (XaJKC)
Administration: Needs domiciliary care worker to administer medication (XaN5J)
Management: Able to manage medication (Xa2yC)
Understanding: Patient does not understand why taking all medication (XaJKX)
^Seen by clinical pharmacist in care home: Yes

Step 3 - Actions

^Structured medication review completed: Yes
Decision making : Shared decision making with patient decision aid (XaYjh)
Medication changes:
Advice to continue with drug treatment (XaAsN)
Advice about drug treatment (Ua02Z)

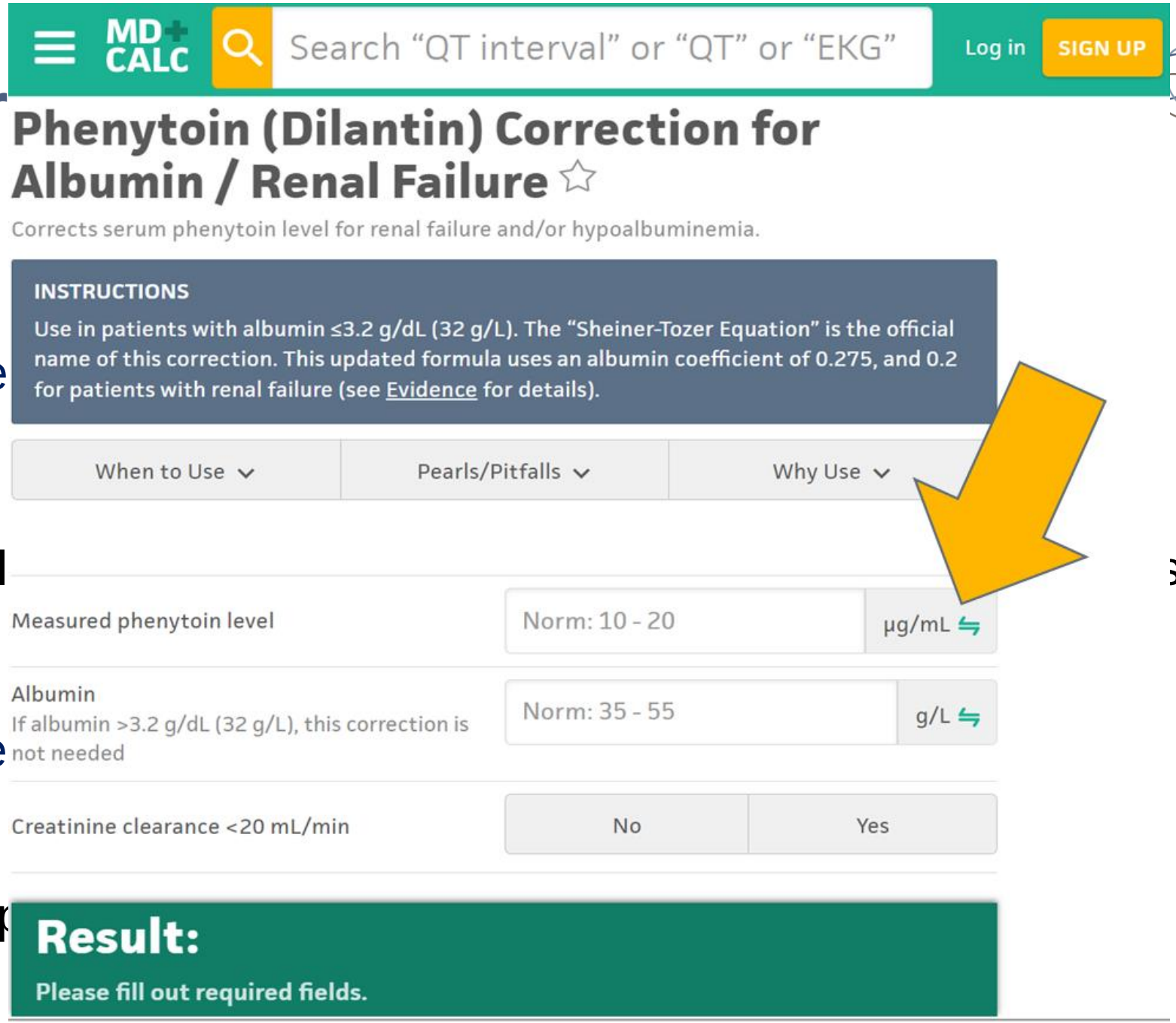
Speech and language therapy (8E21.)
MAR (medication administration record) chart required (XacpR)
Monitoring of all medication checked (XaJKU)
Risk assessment (Ua1P1)
Polypharmacy medication review (XaaCQ)
Indication for each drug checked (XaJJx)
Medicines reconciliation performed (XaRF0)
Lives in a residential home (XaImT)
Requested (Ub1kT) - Nurse/Carer at Care Home
Discussion about treatment with carer (Xabgo)
Parent / carer present at assessment (Y1517)
Drug not taken - problem swallowing (XE0hm)
Partial adherence to medication regimen (XaZBU)
Drug formulation appropriate (XaJKC)
Needs domiciliary care worker to administer medication (XaN5J)
Able to manage medication (Xa2yC)
Patient does not understand why taking all medication (XaJKX)
Seen by clinical pharmacist in care home (Y20a7)
Structured medication review (Y282b)
Shared decision making with patient decision aid (XaYjh)
Advice about drug treatment (Ua02Z)
Advice to continue with drug treatment (XaAsN)

17 May 2022 09:26	The Argyle Surgery, Surgery: xxxx, xxxx (Nurse Access Role) Entered at: The Argyle Surgery
	History: Called home last night at 10pm to check on Lucy. Notes typed in retrospect as I had already logged off of my laptop. Discussed with pharmacy team earlier in the day to say she was drowsy and they felt it may be due to her medication. Examination: Discussed at weekly MDT plan to check bloods and phenytoin levels to see if dose needs adjusting. Diagnosis: Called care home spoke to carer xxxx. xxxx reported that Lucy was awake and alert when she was providing personal care 30 mins before. Lucy reported to be sleeping as time of call. Staff also said no new concerns handed over from day staff. Day staff reported all residents were well. Plan: Advised will call back tomorrow to discuss on weekly rounds.

17 May 2022 19:02	Surgery: xxxx, xxxx (Dr) (Clinical Practitioner Access Role) Entered at: The Argyle Surgery	
	Clinical Information: MEDICINES MONITORING + COMPLAINING OF BEING TIRED Serum phenytoin level (XE25c) 26.5 mg/L [5 - 20] Above high reference limit Serum phenytoin level Report, Abnormal, Other: Dose to be adjusted – contact GS - instructions to follow. Result reviewed by xxxx, xxxx (Dr) @ The Argyle Surgery at The Argyle Surgery (NHS North West London Icb - W2u3z) - 18 Feb 2022 16:45	

18 May 2022 10:59	Surgery: STRETCH, Graham (Dr) (Pharmacist) Entered at: The Argyle Surgery
	Phenytoin level 26.5 total using Sheiner Tozer equation free phenytoin level is 33.97. (range up to 20) Corrected = Observed concentration concentration/ ((0.02 x albumin) + 0.1) Spoke with xxxx, as non verbal slurred speech etc cannot be fully assessed but denies any new eye rolling or unusual eye movements, limb or finger movements. Asked to hold phenytoin for two days. Long half life (up to 42 hours) propose to reintroduce at -56% eg 120mg with a rough target of adjusted 15mg, check TDM levels on Monday week (after 7 days). Estimated creatinine clearance (Cockcroft-Gault formula) (Xaccy) 65.54 mL/min Epanutin 30mg/5ml oral suspension (Viatris UK Healthcare Ltd) - 500 ml - (generic name phenytoin) 120mg (20ml) each morning starting 21/2/22 (hold all phenytoin on 19th and 20th May 2022) Ended 14 Mar 2022 Re-Authorised ETP Medication Cancellation Sent

Sheiner



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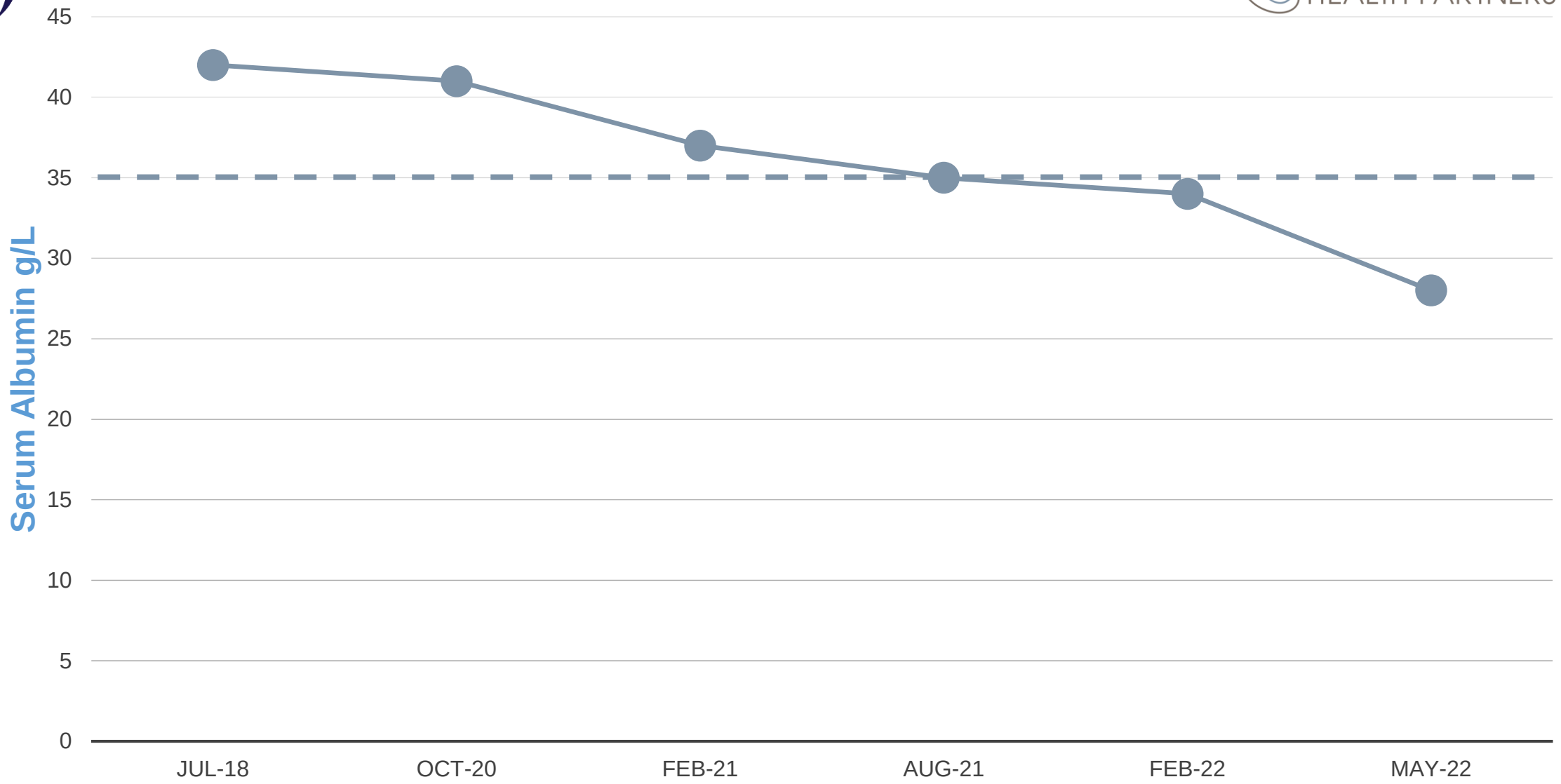
Serum Albumin g/L
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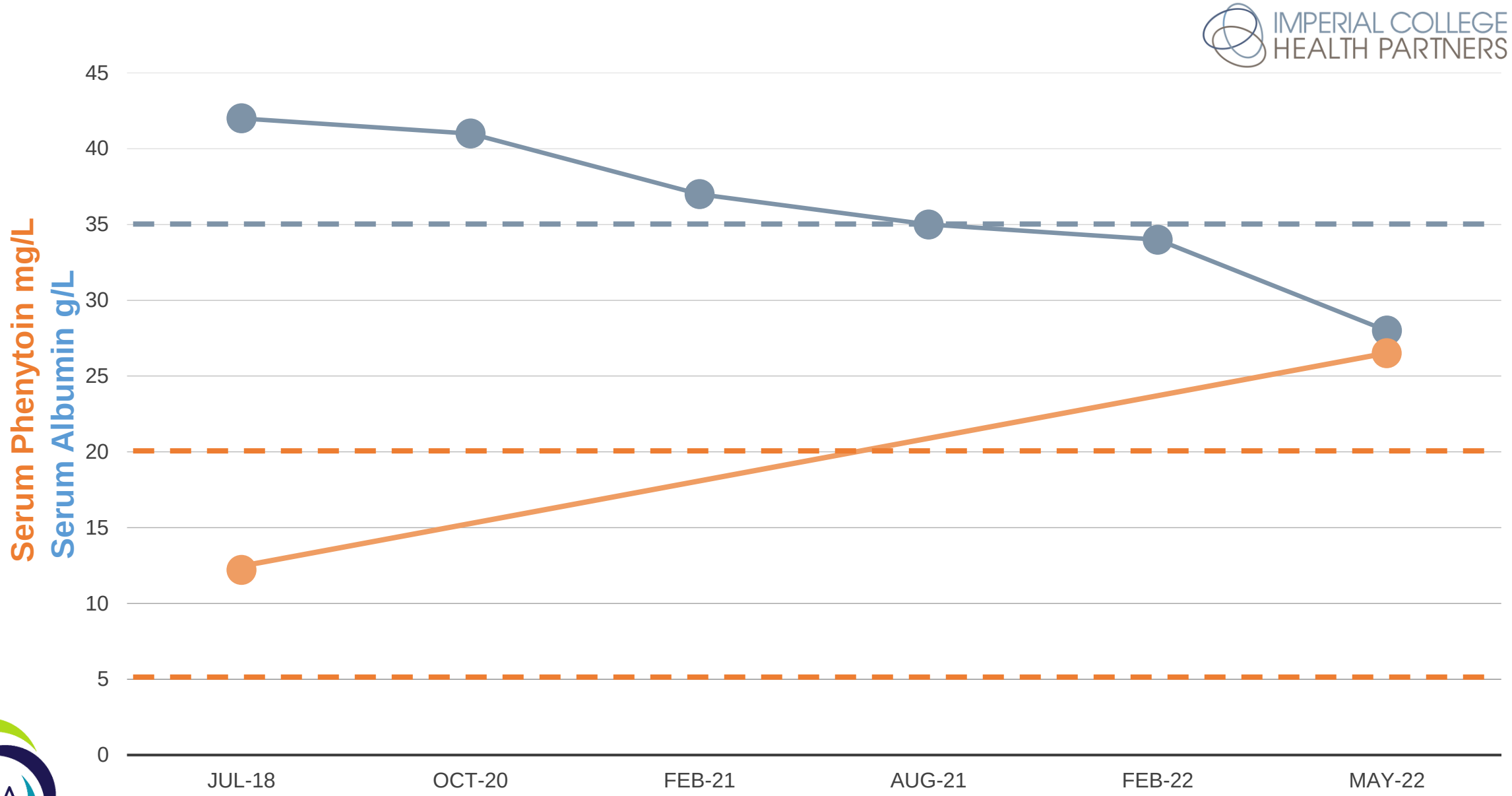
Serum Phenytoin mg/L
Serum Albumin g/L
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AUG-21
FEB-22
MAY-22

25 May 2022 14:42	Surgery: xxxx, xxxx (Nurse Access Role) Entered at: The Argyle Surgery
	History: Face to face consultation to assess Lucy's drowsiness. Examination: Lucy seen nursed upright in bed. Alert and awake. Following me with her eyes. Unable to verbally communicate but visit done in her best interest. Lucy was focused watching her TV when I arrived into the room. Staff report since reduction in Phenytoin dose that she is more alert for longer hours in the day. Not difficult to wake. Needs assistance with feeding but eating and drinking well. Passing urine well large amounts into her pad. Nil urine malodour. Bowels opened this morning and yesterday morning soft stool. Staff report no episodes of seizures. Vitals signs:136 / 78mmHg, O/E - pulse rate (242..) 63 bpm, O/E - temperature (XaBzA) 36.9 degC, O/E - rate of respiration (235..) 18 Resp/min, Oxygen saturation at periphery (X770D) 92 %to 93% on room air. Plan: - Staff to monitor and keep record of any seizure like event. - For blood test on Monday to check Phenytoin levels again to see if it has come down and is within normal range. - Sats range 88-92% if drops below staff advised to contact us.

27 May 2022 10:02	Surgery: STRETCH, Graham (Dr) (Pharmacist) Entered at: The Argyle Surgery
	Clinical Information: HIGH PHENYTOIN LEVELS FOLLOWING DOSE ADJUSTMENT Serum phenytoin level (XE25c) 8 mg/L [5 - 20] Serum phenytoin level Report, Normal, No Further Action. Result reviewed by STRETCH, Graham (Dr) @ The Argyle Surgery at The Argyle Surgery (NHS North West London Icb - W2u3z) - 27 May 2022 10:01

Drugs highly bound to plasma protein

To albumin	*To α_1-acid glycoprotein*
Barbiturates	β-blockers
Benzodiazepines	Bupivacaine
NSAIDs	Lidocaine
Valproic acid	Disopyramide
Phenytoin	Imipramine
Penicillins	Methadone
Sulfonamides	Prazosin
Tetracyclines	Quinidine
Tolbutamide	Verapamil
Warfarin	

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Case 3 : Dysphagia and Covert Administration

Dysphagia -

to Covert or not to Covert?

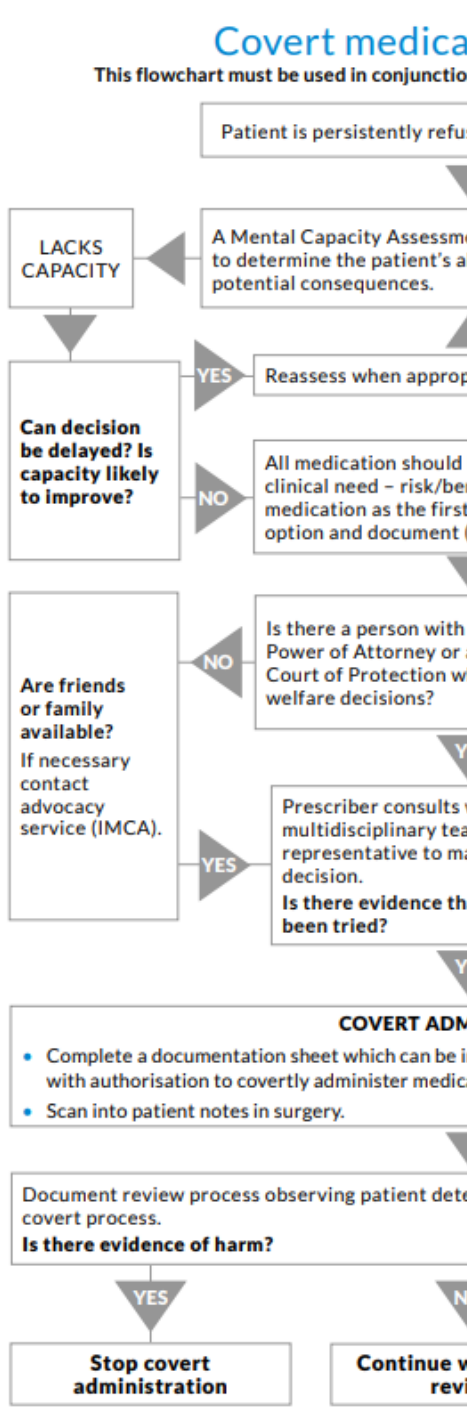
- Consult & Listen
- OPTIMISE!
- Time – Taste – Preference – Staff – Training - IDDSI
- Capacity – Best Interests – Record keeping

Covert administratio

These guidelines detail the pathway th
to administer a medication covertly, th
An overview of the legal considerations
resources to aid understanding of this

Recommendations

- Prescribers should no longer use i
verbal or brief written instruction
- Take the most appropriate action f
consequences of their decisions us
- Clarify the reason(s) for an individ
present a resolution which does n
- Review medication and consider w
line approach.
- Test mental capacity against the fi
administration is considered as an
- The person directly concerned wit
assessment form to carry out the a
- Complete a Best Interest Decision
medication should be documented
- Any organisation considering cove
ensure best practice where covert
support the development of local
- Agree the steps to be taken when
The covert medication flow chart (
- Covert administration should be u
regularly, transparent, inclusive ar
administration should be reviewed
each individual.



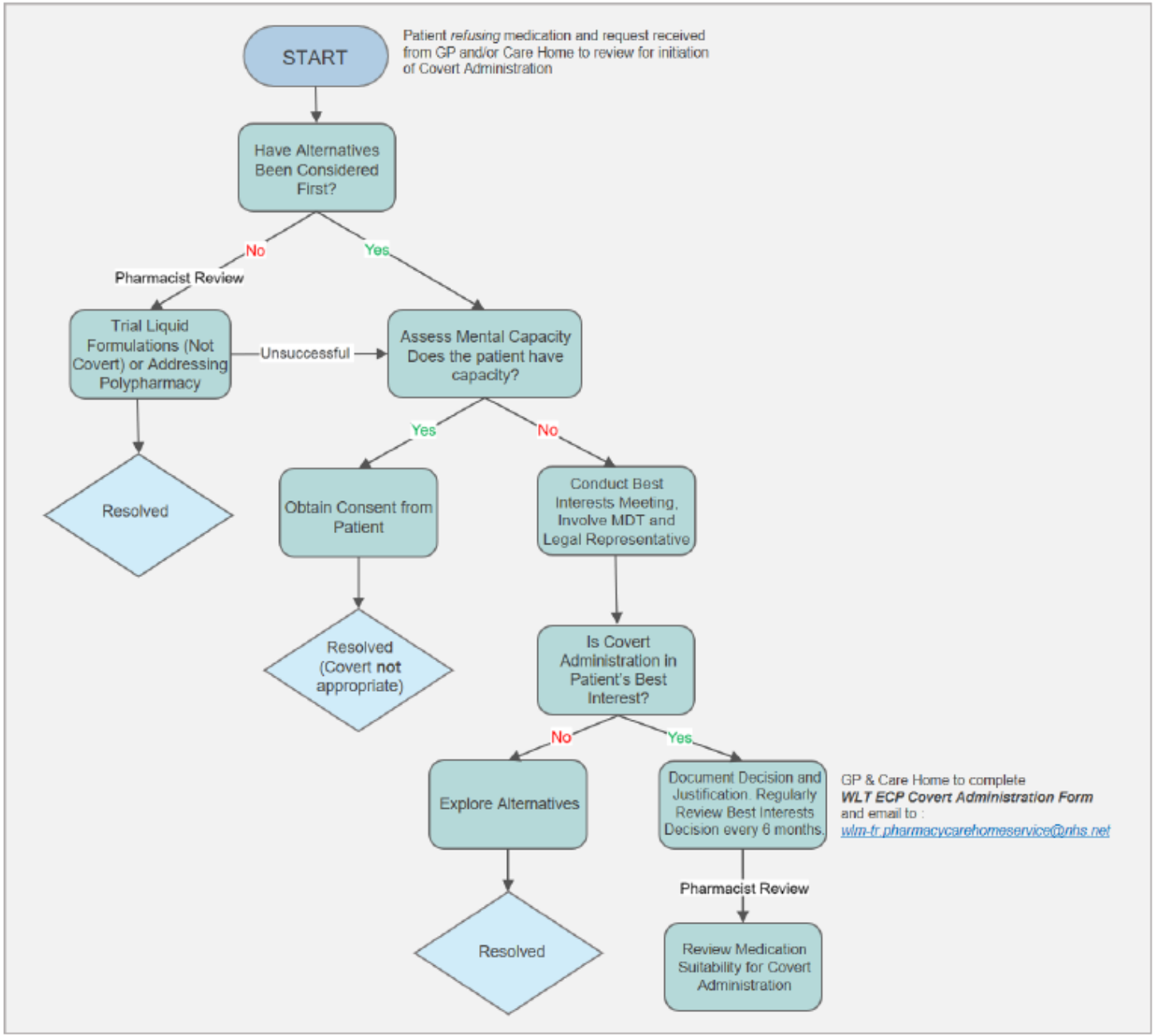
Covert medication care pathway - Best interest decision

Please provide a copy of this pathway to the care home staff supporting the patient and scan into the patient notes at the GP surgery.

Name of patient			
Date of birth		Location	

• What treatment is being considered for covert administration? It has been confirmed that no advanced decisions are in place concerning this treatment.		
	Confirmed by	
	Signature	
• Why is this treatment necessary? • How will the person benefit? • Could this treatment be stopped? Where appropriate, refer to clinical guidelines, e.g. NICE.		
• What alternatives did the team consider which were not successful? E.g. Other ways to manage the person or other ways to administer treatment. • Why were they not appropriate?	State the options tried.	
Treatment may only be considered for a person who lacks capacity. • When was Mental Capacity Assessment (MCA) for this issue completed?	Date	
	Assessed by	
• Who was involved in the decision? N.B. A qualified pharmacist must give advice on administration if this involves crushing tablets or combining with food and drink as it may be unsuitable. If there is any person with power to	Name of healthcare practitioner staff involved	

1. **Figure 1: Assessing the Need for Covert Administration**



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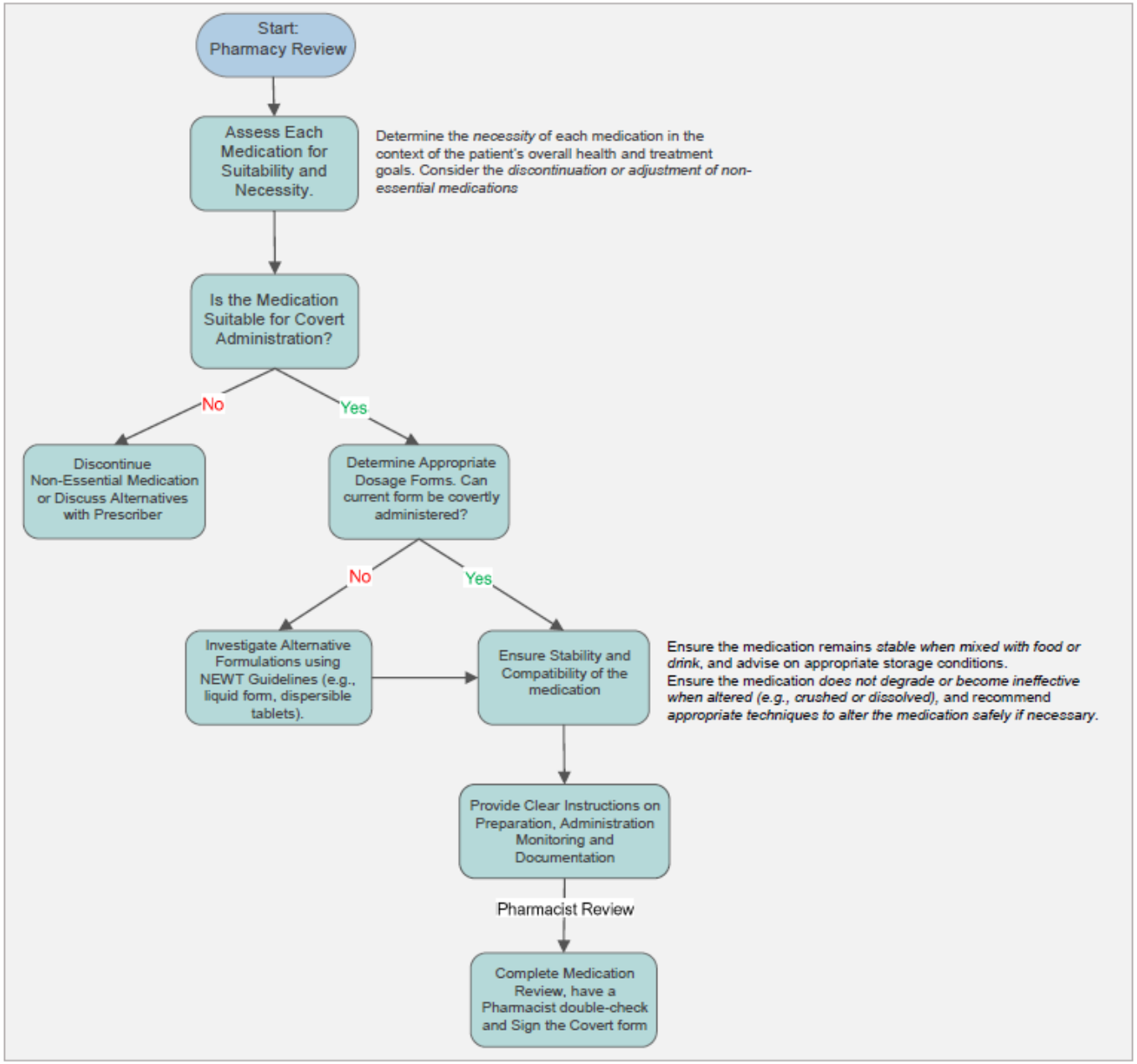
Jeta Thaci
Ealing
Community
Partners

2. **Figure 2: Reviewing Medication Suitability for Covert Administration**



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Jeta Thaci
Ealing Community Partners

NHS
Ealing Community Partners

COVERT ADMINISTRATION OF MEDICINES MDT CARE PLAN

Section 1: Personal Details

Service User Information:

Patient Name	
NHS Number	
Date of Birth	
Care Home/Address	
Date	

Key Contacts:

Patient Next of Kin / Advocate / Power of Attorney / Court of Protectio	
Name	Role

Named Health Care Professionals (HCP)	
Role	Name
Medical Doctor/ Mental Health Professional	
Lead Nurse/ Senior Carer	
Pharmacist	
Other HCP	

Statement of Purpose :
The service user in question does not have mental capacity at present for taking their medicines. Consequently, a best interest meeting was held wi medical doctor or mental health professional, a pharmacist, and a family was agreed that covert administration of medicines is in the service user's approach will be subject to regular reviews to ensure its continued appro effectiveness.

Section 2: Capacity Assessment

Assessment -	
Is the service user actively refusing medication?	Yes
Have alternative measures been considered to avoid resorting to covert administration?	Yes
An assessment has been performed to confirm the service user lacks capacity to consent treatment *(as defined in the Mental Capacity Act 2005).*	*Assessed by:* *Designation:* *Signature:* *Date of assessment:* *Next review date:*

Section 3: Best Interest Decision

All participants should provide their written agreement to the decision.	
Patient Next of Kin / Advocate / Power of Attorney / Court of Protection Appointee	*Print Name:* *Signed:* *Dated:*
Medical Doctor/ Mental Health Professional	*Print Name:* *Designation:* *Signed:* *Dated:*
Lead Nurse/ Senior Carer	*Print Name:* *Signed:* *Dated:*
Pharmacist	*Print Name:* *Signed:* *Dated:*
Other HCP Role:	*Print Name:* *Signed:* *Dated:*

Section 4: Medication Details

Medication and Administration details
Details of the medications, including their names, dosages, frequencies, and purposes, should be clearly outlined in the Medicines Administration Record (MAR). All staff responsible for administering medications must adhere strictly to the instructions provided by the pharmacist as documented in the MAR. If there is any uncertainty or lack of clarity regarding the administration instructions on labels or MAR charts, staff should seek guidance or training to ensure correct and safe administration of the medications.

Section 5: Review Schedule

Review Frequency	
Next Scheduled Review	
An immediate review of the covert administration plan will be triggered by any significant change in the service user's condition, adverse reactions to medication, observed lack of efficacy, changes in medication, staff concerns or errors, legal or ethical issues, feedback from family or advocates, or updates to relevant regulations or policies.	

Section 6: Notes

Notes: (Include any advance directives or informal instructions/wishes the service user may have expressed)

care home charter for medicines (adults)

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When I am staying in a care home, I expect the people responsible for my care to:

1. Actively involve me in decisions about my medicines
2. Help and support me to make shared decisions about my medicines
3. Involve me in regular monitoring and review of my medications and make sure I understand why this is being done
4. Make sure that medicines are given to me in a form and route appropriate to my needs and abilities
5. Make sure that medicines will only be given with my consent unless I lack the capacity to do so
6. Respect the advance decisions or directives I make regarding refusing medicines
7. Make sure that medicines are not given to me hidden in my food or drink unless it is in my best interests and all legal requirements have been met
8. Examine my mouth to ensure that my oral health needs are being met
9. Recognise when I am unable to swallow safely

As a professional working in a care home, I must have the requisite knowledge and skills to:

1. Identify and respect the resident's wishes and beliefs about medication
2. Involve and support the resident and/or those important to them to make shared decisions about medication
3. Involve the resident I care for in regular medicines optimisation reviews by a multidisciplinary team
4. Assess, monitor, administer and review medication to ensure that the resident receives medication safely and in an appropriate form and route
5. Only administer medicines in line with local covert medication policy and the guidance of the Court of Protection
6. Make sure an advance care plan, which includes medication, is in place for the resident, with a regular review when their condition changes
7. Work with other members of the multidisciplinary team to ensure that the resident's medication needs are met
8. Make sure that optimal oral and dental care is provided for residents
9. Recognise and manage swallowing problems to ensure appropriate referrals are made

The charter relates to NICE guidance 'Managing medicines in care homes' SC1 2014.

This document was developed by a specialist panel comprised of nurses, pharmacists, specialist speech and language therapists, care of the elderly physicians, an expert in healthcare law, care home staff and the Patients Association. The project to develop the charter was funded by an unrestricted educational grant from Rosemont Pharmaceuticals who had no role in the design of the project, in the collection of or analysis of data. The charter was piloted in England, Wales and Northern Ireland.

Review date:
September 2021
www.patients-association.org.uk

NCF · JEWISH CARE · Royal College of Nursing · the patients association · Endorsed by ROYAL PHARMACEUTICAL SOCIETY · Qni The Queen's Nursing Institute · BGS · PCPA

Audit : Survey of medicines related care of residents with dysphag

1 How many residents do you have in your home?

2 Do you have any residents/Patients with swallowing difficulties?

Yes/No

3 If so how many are affected in this way

4 How frequently do you have to do the following?

- Crush tablets
- (Daily, more than once a week, weekly, monthly) (delete what does not app
- Melt or disperse tablets before administration
- (Daily, more than once a week, weekly, monthly) (delete what does not app
- Split tablets
- (Daily, more than once a week, weekly, monthly) (delete what does not app

5 If you have to crush/melt or disperse tablets how often do you get authorisation f

6 Before you have to crush/melt or disperse tablets how often to you first seek pharmacist?

7 What is your experience of trying to get authorisation from a doctor or advice fror in such circumstances?

8 Are you aware of different medicines which should not be crushed/dispersed or me which apply based on response to question)

- Medicines where a small change in dose can increase the chances of sid
- Medicines which are designed to delay the release of the drug into the l
- Medicines which are coated to protect the drug
- Medicines which are coated to protect the stomach
- Medicines which are coated to release the drug after the stomach
- Medicines which are coated to hide the taste

9 How frequently do you have to mix medicines with food to make them easier to a

(Daily, more than once a week, weekly, occasionally) (delete what does not apply)

10 How frequently do you think you might miss giving doses because you have to w melt?

11 How frequently do you hold off giving doses because it is difficult to administer t

12 Do you have a protocol for covert administration?

Yes/No

13 If 'No', would such a protocol be useful to you or your staff?

14 Are you aware of the relevant legislation relating to covert administration of medication?

What do you understand to be the requirements of the legislation?

15 What circumstances are you aware of where it would be lawful to administer medicines covertly to a resident?

16 In your view who has the authority to authorise medicines to be administere

17 When would you consider covertly administering medicines?

18 Do you have a protocol for administering medicines to residents with dysph swallowing)?

Yes/No

19 If 'No,' would such a protocol be useful to you or your staff

20 Do you have blanket permission to crush/disperse/melt medicines from provide care to your home?

Yes/No

21 Do you have blanket permission to crush/disperse/melt medicines from any relatives?

Yes/No

22 How would you describe your awareness of the laws that regulate the medicines?

What particular requirements are you aware of that arise from these laws?

23 How confident are you of your knowledge regarding the laws whi crush/disperse/melt medicines?

If you are confident, what are the particular requirements that you are aware o

24 How would you describe your awareness of the requirements of your social care regulator (CQC, CSSIW, SCRC, RQIA) in relation to administering medicines?

What requirements are made by the regulator?

25 Have you and your staff been actively trained in administering medicines to residents with dysphagia in the last five years?

26 Under what circumstances would a resident be reported to be having swallowing difficulties (what would suggest that they might be experiencing problems in swallowing)?

27 Do you actively look for swallowing problems in your residents?

28 When you identify a resident with swallowing problems what actions would you take? (tick all of the steps described by the respondent):

- Seek a professional assessment of the swallow
- Identify the types of food which are most easy for them to swallow
- Identify how best to administer their tablets and capsules
- Tell their relatives
- Tell their doctor
- Ask for a review of their medicines by the doctor
- Ask a pharmacist what the different medicine options are available

29 Are there any barriers to providing the most appropriate medicines for residents who are unable to swallow safely? If 'yes' please describe what these are.

30 Do you have a protocol for residents who refuse their medication?

Yes/No

31 If 'No,' would such a protocol be useful to you or your staff

Clinical Audit Report Te

Title of Audit Audit of home awareness and policy for dys medicines

Date of Audit ##-##

Who was involved in the audit?
(List of people including designation)
###

Background
(This should include a brief description of the reason for selecti
To assess how patients withdysphagia were being manage areas where improvement could be made.

Preparation and planning
(How you intend to carry out the audit e.g. records search)
A qualitative study based on an audit checklist which is di manager and/or a senior nurse.

Aim of the Audit
(This should identify what you need the audit to tell you e.g. is particular piece of guidance i.e. NICE guidance/local)
To identify if current practice followed guidance in the ## s

Criteria
(This section identifies the aspects of care which you are going defined)
The audit looked at six key areas using a checklist. These resident in decision making, medicines monitoring and rev advanced care plans, swallowing deficits, medicines admi

Initial standard setting
(What are you aiming for 100%, 90% etc)
100%

Analysis and Findings
(This section should outline the level of compliance achieved a compliance not achieved an explanation of why. What was lea
A total of 9 homes were audited. Common areas for impro homes had specific areas to focus on.

In ## home, areas which were not complied with were
- **Recording the intended purpose of all medicines**
- **Evidence that covert medication is still being offere**
- **Frequency of best interest review being recorded**
- **Staff trained in oral care**

In ## lodge, areas which were not complied with were
- **Recording the intended purpose of all medicines**
- **Evidence that covert medication is still being offere**
- **Advanced care plans in place for all patients**
- **Signs and symptoms of dysphagia routinely recorded**
- **Staff trained in oral care**

In ## House, areas which were not complied with were
- **Recording the intended purpose of all medicines**
- **Antipsychotic reviews were not being carried out 6 monthly**
- **Evidence that covert medication is still being offered before administering covertly**
- **Advanced care plans in place for all patients**
- **Routine dental check-up within 12 months**
- **Evidence that teeth/ dentures are cleaned twice daily**
- **Staff trained in oral care**

In The ## homes, areas which were not complied with wer
- **Recording the intended purpose of all medicines**
- **Evidence that covert medication is still being offere**

In ## home, areas which were not complied with were
- **A mental capacity assessment for all patients**
- **Recording the intended purpose of all medicines**
- **Antipsychotic reviews were not being carried out 6**
- **Evidence that covert medication is still being offere**
- **Frequency of best interest review being recorded**
- **Evidence that teeth/ dentures are cleaned twice dail**
- **Staff trained in oral care**

In ## Nursing home, areas which were not complied with v
- **Patient's wishes and beliefs about medicines record**
- **Evidence that people important to patient are involv**
- **Evidence of MDT meetings to review medication**
- **Recording the intended purpose of all medicines**
- **Evidence of 6 monthly covert administration review**
- **Evidence that covert medication is still being offere**
- **Frequency of best interest review being recorded ar**
- **Evidence that advance care plans are reviewed and residents wishes**
- **Evidence if medication review is patient experience**
- **Routine dental check-up within 12 months**
- **Evidence that teeth/ dentures are cleaned twice dail**
- **Staff trained in oral care**

In ## House, areas which were not complied with were
- **Recording the intended purpose of all medicines**
- **Evidence that covert medication is still being offered before administering covertly**
- **Advanced care plan in place for patients in line with their wishes and updated**
- **Routine dental check-up within 12 months**
- **Staff trained in oral care**

In ## Nursing home, areas which were not complied with were
- **Recording the intended purpose of all medicines**
- **Evidence that covert medication is still being offered before administering covertly**
- **Advanced care plan in place for patients**
- **Swallowing status recorded in all patients notes**
- **Evidence that teeth/ dentures are cleaned twice daily**

- **Staff trained in oral care**

Action Plan
1. Each home was given specific feedback from their audit process on areas to work on
2. Each home were given access to resources on the Patients Association website to facilitate learning
3. Homes were asked to complete an online questionnaire at the end of their learning to consolidate their learning

Conclusions and reflections from the audit
(What changes are needed? How will the changes be implemented and who will do this and when?
How was this communicated to the team? When will the re-audit occur?)
Each home was provided with an email summary or photocopy of the audit to see their specific areas that were not already fulfilled. They were offered support from the argyle surgery to meet their goals in the form of online resources and training of staff but it was each homes responsibility to work on improvements. The homes were given between 2-3 months to make improvements before a re-audit occurred.

Re-audit findings
(The re-audit report should include the date of second data collection, the Standard achieved and whether further action is required)
The re-audit occurred between ##. In most homes improvements were made however 100% standard was not achieved. ## Care Home, ## House, ## and ## nursing home still had incomplete covert administration forms which were missing signatures from various fields and review dates. This audit is on-going.

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PCPA

Case 3 – Mrs Patel

- 82 yo – cared for by 86yo husband with daughter locally who has a busy travel agents business. Son in Australia
- Of late aggressive towards husband ?dementia
- Husband admitted with stroke
- Social worker admits Mrs Patel to a home in your care on Thursday afternoon as emergency
- Today is Friday, home manager calls GP as anxious, agitated and refusing meds
- Social worker told home manager she can't swallow husband opens/crushes her meds into tea and juice

Case 3 – Mrs Patel - Medications

- amlodipine 10mg tabs daily
- ramipril 5mg capsules daily
- furosemide 20mg tablets daily
- aspirin 75mg tablets daily
- naproxen 500mg tablets twice daily tablets
- lansoprazole 30mg capsules daily
- levothyroxine 50mcg tablets daily
- citalopram 20mg tablets daily
- tolterodine 2mg twice daily
- prochlorperazine 5mg three times a day
- haloperidol 500mcg twice daily

Case 3 – Mrs Patel – Plan (Fri pm)

- Manager says staff want a ‘crush order’
  - What do we do?

- Temporary patient – limited Hx – immediate actions

- If becomes permanent – Care plan?

Resources

NHS North East Essex | Colchester Hospital University NHS

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SwallowingDifficulties

Home About Patients Healthcare Professionals News & Events Blog Links Resources

Enter your current medicine

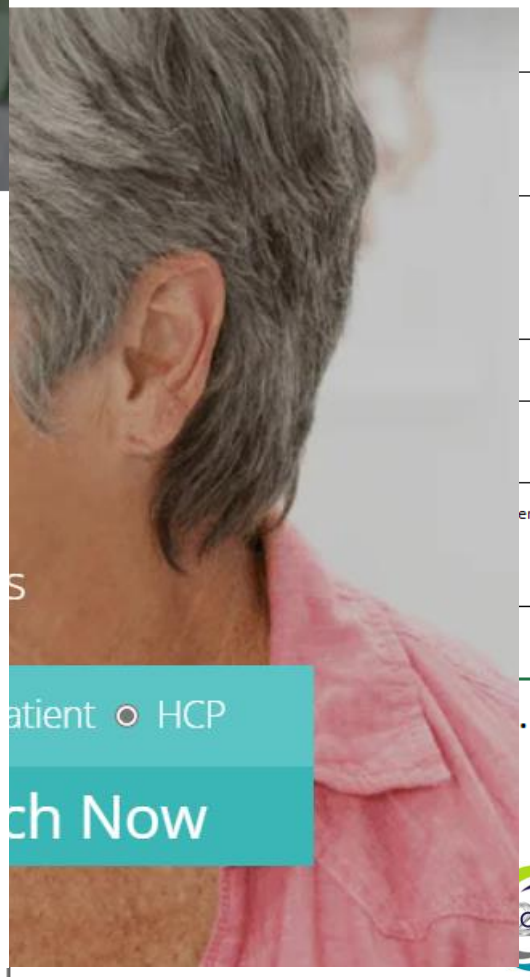
I'm a Patient HCP

Search Now

Alfacalcidol

(One-Alpha®, Alfacalcidol)

Available as tablets or capsules.	Capsules
Available as soluble tablets?	No
Available as a liquid?	Yes - Drops
Available as something for placing under your tongue?	No
Available as something for placing on your gum?	No
Available as granules?	No
Available as a patch for putting on your skin?	No



Case 4: Acute on Polypharmacy

Peters, A (Mr)

Mr Peters (83yo) has a three day history of diarrhoea and vomiting, he thinks he ‘ate something bad’ at the weekend.

Booked into your clinic as a same day from triage. He appears frail, pale and dry. He is apyrexic and denies blood or mucus in his stools. No recent travel.

1. **Plan for today?**

2. **Plan for review?**

Patient Summary: Problem Based

Peters, A (Mr) **NHS Number: 123456789**

Date of Birth	06 Apr 1941 00:00 (83 y)	Gender	Male
Language	Main spoken language English	English Speaker	Yes

Contact Details

Current Home Address	26 Yellow Brick Road, London W5 1AA	10 Jun 2004

Registration Details

Usual GP	Cares, Ian (Dr)	Home GP

08 Sep 2024	At risk of unplanned admissions. Named GP Dr Cares. Score 98.38	Normal Priority

Active Problems

Knee pain (Xa0wx)	∞
Back pain (XM1GI)	21 Aug 2007 - Ongoing
Hypertension (XE0Ub)	11 Mar 2017 - Ongoing
Mixed anxiety and depressive disorder (X00Sb)	03 Feb 2015 - Ongoing
Type II diabetes mellitus (X40J5)	03 Feb 2018 - Ongoing
Atrial fibrillation (G5730)	03 Feb 2020 - Ongoing
Rhinorrhoea (XM00h)	21 May 2021 - Acute
Bacterial pneumonia NOS (H22z.)	12 Aug 2022 - Ongoing
Infection of the upper respiratory tract (Xa2o8)	06 Aug 2023 - Acute
Osteoarthritis (XE1DV)	13 Aug 2023 - Ongoing
Myocardial infarction (X200E)	01 Jun 2024 - Ongoing
Chronic kidney disease stage 3A with proteinuria (XaO3p)	01 Jun 2024 - Ongoing
Admission avoidance care plan agreed (XabFm)	14 Aug 2024 - Ongoing

Current repeat templates

01 Feb 2025	Aspirin 75mg dispersible tablets	take one daily	28 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Citalopram 10mg tablets	1 Every Day	28 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Citalopram 20mg tablets	1 Every Day	28 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Amlodipine 10mg tablets	1 Every Day	28 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Indapamide 1.5mg modified-release tablets	take one each morning	30 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Naproxen 500mg tablets	take one twice daily	56 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Perindopril erbumine 4mg tablets	take one daily	30 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Simvastatin 40mg tablets	take one at night	28 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		
01 Feb 2025	Metformin 500mg tablets	1 To be taken Twice Daily	56 tablet	
Issues: 1 out of 4		Review: 01 Aug 2025		

Current acute medication

A = Acute P = Private I = Instalment Dispensed D = Dental H = Hospital O = Other

01 Feb 2025	Sodium alginate 500mg/5ml / Potassium bicarbonate 100mg/5ml oral suspension sugar free	5ml or 10ml 4 times/day	500 ml	A

Latest blood tests

Other Biochemistry Overview

Haemoglobin A1c level - IFCC	78 mmol/mol	17 Mar 2024
Haemoglobin	11.2 g/dl	17 Mar 2024
Serum cholesterol level	3.4 mmol/L	

Biochemistry Urinalysis Overview

Urine Glucose Concentration	Urine glucose test = trace (4663.)	13 Aug 2024
eGFR	40 mL/min [60 - 99,999	13 Aug 2024

Investigation		Result
Urea and electrolytes (X77Wi)	13 Aug 2024	
Serum sodium level (XE2q0)		141 mmol/L [133.0 - 146.0]
Serum potassium level (XE2pz)		4.3 mmol/L [3.5 - 5.3]
Serum urea level (XM0lt)	Above range	8.1 mmol/L [2.5 - 7.8] Above high reference limit
Serum creatinine level (XE2q5)	Above range	134 umol/L [60.0 - 125.0] Above high reference limit

Last Appointment

12 Jan 2025 Patient Plan Reviewed: 31 Dec 2025

Care Goal:

1) Support for independent activity

2) Hypertension goal <130/80 (Today 143/89 mmHg)

1. Plan for today?

2. Plan for review?

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Approach to Polypharmacy and Deprescribing

Everybody's business

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- Structured approach integrated with clinical judgement is required.
- Acknowledge some meds may be restarted – it's a trial
- Full engagement of patient, family, carers is imperative and honesty all round
- The MDT
  - Community pharmacists
  - Share the workload with PTs/Hosp pharmacists/specialists
  - Patients, relatives, carers, OTs, nurses etc can monitor drug effects and feedback
- Focus on patients with the highest medication related risks and morbidities
- For individual patients, focus on the drugs with the highest risks or highest benefits

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Open Discussion and Q&A

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12/02/2025 Fiendish Cases - Learning from Real Life Polypharmacy

Future Polypharmacy Masterclasses

We would appreciate input from our attendees regarding feedback from today's sessions and potential topics for future masterclasses

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Thank you & Close