Deprescribing in Older Adult Psychiatry Wards: A Quality Improvement Project

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Background

The term “deprescribing” refers to the process of optimising a patients medications by reducing or discontinuing those for which the benefits no longer outweigh the risks (1,2). The increasing rates of polypharmacy and growing mindfulness of side effects, particularly in the elderly population, necessitate a focus on deprescribing in psychiatry (2).

The project had a general deprescribing approach and did not focus on any specific drug categories. We aimed examine the feasibility of deprescribing on older adult psychiatry wards. One ward was a specialist dementia unit at University Hospital Monklands and the second was a functional ward at University Hospital Wishaw. We predicted that deprescribing could decrease the medication burden on this patient population if recommendations were enacted by clinicians.

Methodology

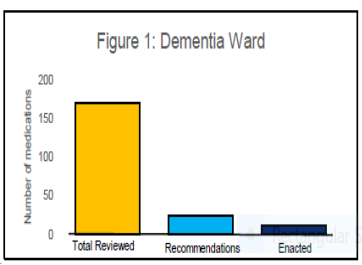
- To undertake deprescribing recommendations across two psychiatry wards among a team that consisted of a clinical pharmacist as well as a psychiatric and geriatrics higher trainee between March and May 2024.
- Reviewing the Hospital Electronic Prescribing and Medicines Administration (HEPMA) to see how frequently medicines were being utilised, blood results and letters on clinical portal, electronic recording system entries, physical observations on Patientrack and the STOPP START Medication Review Tool (3).
- To feed back the deprescribing recommendations to the responsible consultants electronically.
- Collecting demographic and clinical information and types of deprescribing recommendations and their observed acceptance four weeks after the recommendations were provided.

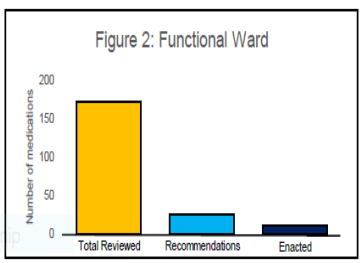
Disease areas

- Diabetes
- Hypertension
- Cholesterol reduction
- Epilepsy
- Osteoporosis
- Angina
- Heart failure
- Dementia
- COPD
- Analgesia
- Mental Health

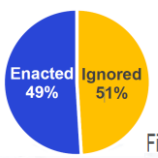
Results

- Dementia ward: There were 14 patients (mean age 76.7yr and 11.5 co-morbidities) and a total of 171 medications (average 12.2 per patient) were reviewed and 25 medication recommendations were made. Out of these, 11 were enacted or 44%.
- Functional ward: There were had a total of 19 patients (mean age 73.1 years and 9.4 co-morbidities) and a total of 184 medications (average 9.7 per patient) were reviewed and 26 medication recommendations were made. Out of these, 14 were enacted or 54%.





- Across the two wards, the consultants accepted 49% of the deprescribing recommendations, resulting in a reduction of the medication burden by 25 medications (0.75 per patient).



The most common medications discontinued: sedative hypnotics, analgesics, laxatives, antihypertensive, statins and folate.

Figure 3: Med Recommendations

Conclusions

- This project demonstrated that deprescribing interventions in the form of making recommendations within a multidisciplinary team are feasible, effective and reduce medication burden.
- In the future, it could be examined if clinical pharmacist-led deprescribing could be initiated. Future work should focus on working alongside the responsible consultant and patient more closely with regards to the recommendations and potentially including educational sessions to aid in the deprescribing process. This would likely increase the total number of recommendations accepted.
- Looking at any adverse events due to withdrawal of an agent could give a more complete picture of the process.

References:
1. Hung A et al. Deprescribing in older adults with polypharmacy. BMJ 2024;385:e074892. doi 10.1136/bmj-2023-074892
2. Gupta S., Miller R., Cahill J. D. (2019). Deprescribing in psychiatry. Oxford University Press.
3. O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. Age Ageing. 2015;44(2):213–218.