Frailty and polypharmacy are linked!

This article is the third of a series of four articles on frailty, prepared by Dr Chris Bollen of BMP Consulting for the Hunter New England Central Coast Primary Health Network frailty early intervention program.

Changing the trajectory of frailty in older people

Frailty is now recognised as the most significant challenge to ageing well in Australia, with more than 20% of people becoming frail as they age[1].

Screening tools, such as the FRAIL Scale, can be used to assess people aged 65+ who are at risk of frailty.

Pleasingly, the trajectory of functional decline can be plateaued - if not reversed - through interventions such as building muscle with resistance exercises, addressing fatigue, protein and calorie supplementation, and deprescribing.

This article looks at the links between frailty and polypharmacy, the importance of accurate medication lists, weight loss and protocols for deprescribing.

Medication review - an evidence-based approach to health improvement

Frailty is a multisystem impairment associated with increased vulnerability to stressors, such as adding new medications.

Susceptibility to existing medications can also increase as an older person's overall function declines. This is especially true with reduced mobility and reduced cognition, both of which are impacted by medication interactions.

Many medications cause fatigue, reduce physical activity and impact balance (which slows walking speed), and their side effects - such as feeling dizzy or unsteady - can make an older person prone to a fall.

Taking several medicines, or certain types of medicines (e.g. sleeping tablets or opioids) can also increase the risk of falling.

Often the issue is not the individual medication, but the combination prescribed (e.g. a diuretic, anti-inflammatory medication and an ACE inhibitor, or a renally cleared medication in a patient with eGFR < 60mls/minute (stage 3a Chronic Kidney Disease (CKD) or worse). If the combination of CKD and polypharmacy is not recognised, it is a patient safety issue. This occurs more frequently than most GPs realise.

Consider this group's multimorbidity:

- 50% of people aged 65+ have at least two long term health conditions,

[1] Professor Ruth Hubbard, Geriatrician

- 40% of people aged 75+ have CKD (frequently not recognised, not coded in the medical prescribing software, or managed), and
- 50% of people aged 75+ are taking more than five medications per day.

The intersection of these groups suggests that 20+% of older patients will be impacted.

Maintaining accurate medication lists

Consequently, updated and correct medication lists are critical, especially for older patients.

The introduction of ingredient prescribing has confused many older patients who are used to remembering medications by brand name.

Older people may not recall every medication they take, or what has been altered by another prescriber, so review of the patient's My Health Record can be very useful to see what has been dispensed.

Many patients take multiple medications, so over-the-counter medications also need to be listed and drug interactions need to be carefully monitored.

Weight measurement and management

Weight loss has many causes and many flow on effects. For example, it can impact medication metabolism, increasing its effect/risk as weight reduces and renal function deteriorates.

Older patients should therefore be weighed at every GP visit, and medications should be reconciled after each hospitalisation or visit to another clinician. Medications should also be reviewed annually and the "reason for prescription" should be clearly documented.

These simple steps reduce the potential for medication errors. They are more vital in areas with medical practices which are open seven days/week, where doctors regularly see each other's patients. Tenanted doctors working in General Practices should be aware of their duty of care to ensure these practices are occurring[2].

Patient engagement

Supporting patients to be active in their healthcare starts with preparing them to ask the right questions and have necessary information at their fingertips.

The reception team can assist by reminding patients to bring in both prescription and over the counter medications, lists of questions and so on.

Display posters to encourage patients to ask questions, seek information on risks of treatment and consider options in care, for example:

[2] "Good medical practice: a code of conduct for doctors in Australia", AHPRA October 2020, section 10.5.

Tips for our patients!

- Talk to your GP if you feel dizzy, unsteady on your feet or sleepy during the day.
- Ask your GP about the potential side effects of your medicines.
- Ask your GP about having a free Home Medicine Review. A pharmacist will visit your home to discuss your medicines with you and will work with your GP to determine whether any of your medicines need to change.

Deprescribing

Deprescribing is the "systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values, and preferences."[3]

Deprescribing medications (e.g. sedatives, cholinergic medications, opioids, renal toxic medications) can positively impact older people's frailty trajectory.

Deprescribing protocol

A deprescribing protocol may follow the steps below:

1. Ascertain all drugs that the patient is currently taking and the reasons for each one,
2. Consider overall risk of drug-induced harm in patients in determining the required intensity of deprescribing intervention,
3. Assess each drug for its eligibility to be discontinued,
4. Ask the patient their concerns about potential medication changes,
5. Prioritize drugs for discontinuation, then
6. Implement and monitor drug discontinuation regimen:
    a. Inform patient, family and other clinicians
    b. Set expectations (timing, effects to observe)
    c. Determine discontinuation regimen (gradual reduction, cessation)
    d. Monitor for discontinuation symptoms/ return of symptoms of disease
    e. Manage adverse effects by pharmacological/non-pharmacological strategies
    f. Document and communicate success/failure of regimen

A slow reduction - to gain both the patient and their family's confidence of the process - is a useful deprescribing approach. General Practice is well suited to this, due to the continuity of the relationship between older patients and their usual GP.

Additionally, rather than the older person attending the practice for every visit, a video or phone consultation can now be booked to follow up the impact of medication changes.

[3] JAMA Internal Medicine (2015), Scott et al

For example, the GP may give a patient written instructions to take ½ a tablet daily (instead of a whole tablet) for the next 2 -4 weeks, then call to review the outcome of the medication change.

Referral to a consultant pharmacist for a Home Medication Review can also be very useful to assess the patient's knowledge of their medications, how they are stored and any feedback on medication interactions.

Deprescribing resources

Some excellent resources medication reviews and deprescribing are below:

- PSA Guidelines for providing Home Medicines Review Services
- RACGP Medication management
- Deprescribing resources (Primary Health Tasmania)
- Deprescribing Guidelines and Algorithms
- Cumulative Medicines Risk: Addressing the Hidden Risk of Cumulative Medicines Load to Reduce Harm

Yours sincerely,

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