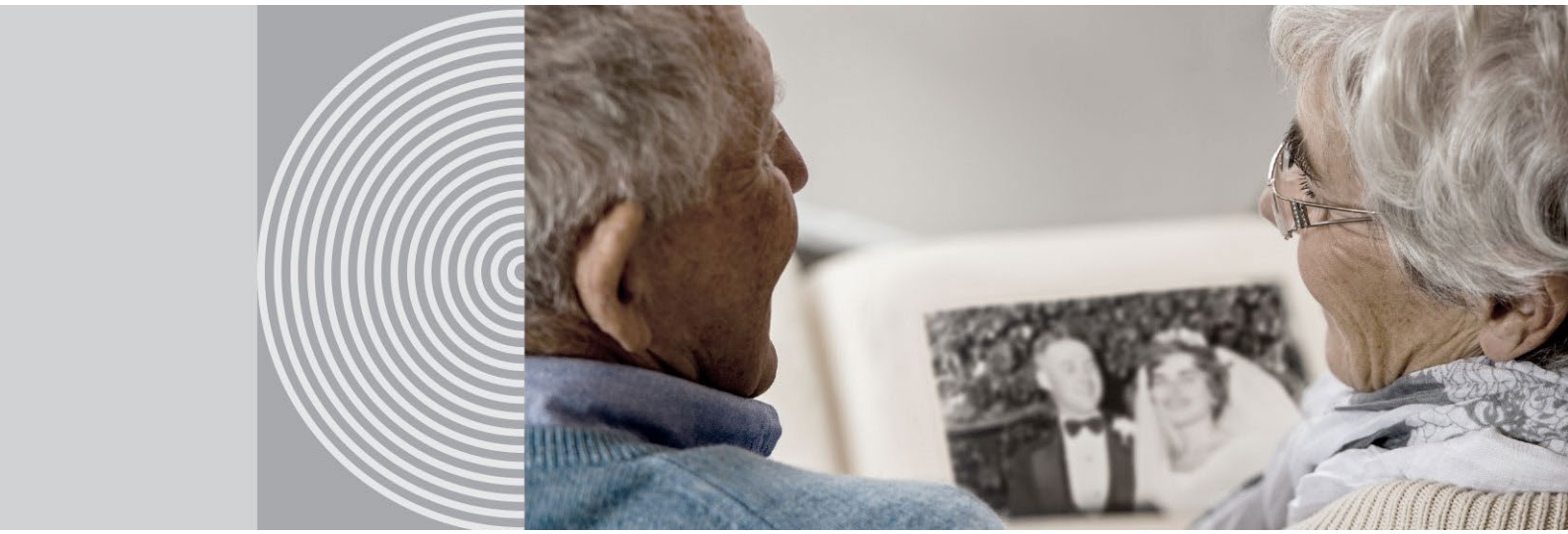
RACGP
Royal Australian College *of* General Practitioners

# *RACGP aged care clinical guide (Silver Book)*

## 5th edition

Part A. Deprescribing



# *General principles*

Deprescribing is a positive, patient-centred intervention, conducted under medical supervision, that reassesses the role of all medicines with a view to stopping those that:[1]

- have no clear benefit
- may cause harm
- are being used for an indication that is no longer an issue
- no longer fit with the current goals of care.

# *Practice points*

| Practice points | References | Grade |
|---|---|---|
| Deprescribing should be undertaken with the assistance of a multidisciplinary care team, and appropriately communicated to all members of the care team | – | Consensus-based recommendation |
| Establish a written tapering plan, especially for classes of medication that require slow tapering (eg opioids, benzodiazepines), to avoid a return of disease symptoms or withdrawal symptoms | 10, 11 | Consensus-based recommendation |
| Explain to the patient that deprescribing is a positive intervention aimed at improving quality of life, and ensuring they do not receive unnecessary medicines with unlikely benefit or potential for harm | 1, 15, 18 | Consensus-based recommendation |
| Review and reconcile medicines with other medicine lists, including those from a Home Medicines Review (HMR) or Residential Medication Management Review (RMMR), patient medicine list or discharge summary, with your current medicine list in your record | 1, 19–21 | Consensus-based recommendation |

| | | |
|---|---|---|
| Assess medicine-related benefits and risk of harm, and discuss options with patient, resident, family and advocate | 1, 19–21 | Consensus-based recommendation |
| Discuss, prioritise and plan any changes with patient and family and advocate to decide and agree on specific medicines to change, generally one at a time, slowly over weeks or months, in a stepwise approach | 1, 19–21 | Consensus-based recommendation |

# *Introduction*

Deprescribing is the process of withdrawal of an inappropriate medication, supervised by a healthcare professional, with the goal of managing polypharmacy and improving outcomes (refer to Part A. Polypharmacy).[1] Deprescribing should be considered at all times as part of good prescribing continuum, not just at the end-of-life stage. It should be undertaken with the assistance of a multidisciplinary care team that may involve general practitioners (GPs), pharmacists, residential aged care facility (RACF) staff, registered nurses, other specialist medical practitioners, and allied health professionals.

Research and evidence in deprescribing is lacking, and needs to be an area of research priority in general practice and RACFs.

# *Clinical context*

## Potential benefits

Potential benefits of deprescribing include:[1,2,3,4,5,6,7]

- reducing potential for drug interactions and adverse effects
- improving function and quality of life (eg may improve cognition and behaviour, and may reduce rate of falls)
- simplifying drug regimens (although this can occur without deprescribing)
- reducing costs for patient and nursing staff (if in care)
- reducing medication errors.

## Potential harms

Signs and symptoms of the original condition may reappear when a drug is withdrawn. If this occurs, consider a reduced dose or frequency (eg from regular to 'as needed' *pro re nata* [PRN] dosing), rather than complete cessation.

Potential changes in pharmacokinetic and pharmacodynamic drug interactions should be considered when deprescribing; for example, international normalised ratio (INR) changes in a patient taking warfarin when an interacting drug is ceased.[1]

The risk of clinically significant adverse withdrawal reactions is rare when deprescribing is undertaken slowly and appropriately under medical supervision. However, while withdrawal reactions may occur, it is important not to interpret these as recurrence of symptoms of the original disease. Withdrawal syndromes may include:

- withdrawal effects (eg confusion, seizures after abrupt withdrawal of benzodiazepines)
- rebound effects (eg rebound tachycardia after withdrawal of beta-blocker, rebound acid secretion with abrupt withdrawal of a proton pump inhibitor).

# *In practice*

A written tapering plan is desirable, especially for classes of medication that require slow tapering (eg opioids, benzodiazepines), to avoid a return of disease symptoms or withdrawal symptoms. A written tapering plan has the potential to optimise the patient's quality of life by reducing medications that are no longer appropriate in their clinical context.[3,8]

Many studies have found the benefits of slow, appropriate reduction of inappropriate medicines in older people, particularly those living in RACFs.[9,10] Many guides for slow structured withdrawal of targeted medicines have been published, including:

- Primary Health Tasmania's Deprescribing resources: One of the most accessible and practical guides.[3]
- Canadian Deprescribing Group's Medstopper: Useful deprescribing tool for health professionals. The Canadian Deprescribing Group also have deprescribing guidelines and an interest group.[11]
- The *Evidence-based clinical practice guideline for deprescribing cholinesterase inhibitors and memantine* has been developed by the University of Sydney, in conjunction with the Bruyère Research Institute.[12] The guideline contains seven recommendations that reflect the current evidence about when and how to trial withdrawal of cholinesterase inhibitors and memantine. The recommendations were approved by the National Health and Medical Research Council (NHMRC) in October 2017, and are directed at healthcare professionals. An algorithm was also developed to assist healthcare professionals in deprescribing.

Table 1 includes some medicines that require care when ceasing.

**Table 1. Examples of ceasing medications in older people**[1,3,13,14,15]

| Class | Comments |
|---|---|
| Analgesics | Withdrawal syndrome would occur with abrupt cessation of opioids |
| Antidepressants | Slow withdrawal recommended with selective serotonin reuptake inhibitors (SSRIs) |
| Antipsychotics | Cessation should be gradual, particularly after long-term use |
| Benzodiazepines | Very slow weaning program recommended at 10–15% per week. Sudden cessation may result in confusion, hallucinations and seizures.[16] Insomnia may occur with sedative withdrawal |
| Beta-blockers | Abrupt cessation may exacerbate angina, or precipitate rebound hypertension, myocardial infarction or ventricular arrhythmias |
| Clonidine, moxonidine | Slow weaning to avoid rebound hypertension |
| Corticosteroids | Slow weaning is only required if patients have had long-term therapy |
| Levodopa | Sudden withdrawal may cause neuroleptic syndrome |
| Proton pump inhibitors | Slow weaning to avoid hypersecretion of acid and aggravation of symptoms |

## Potential barriers to deprescribing

While many patients may be willing to try ceasing medicines, some barriers may exist from a patient perspective, including:[1,3,15,16]

- anxiety and fear of consequences of stopping a medicine that has been prescribed for a long period
- reluctance to stop a drug when a patient believes it may prolong life or improve function
- previous negative experiences with drug withdrawal
- the perception that deprescribing suggests that the patient is 'not worth treating'.

Medical practitioners may also find deprescribing challenging for several reasons, including:[1,3,17]

- adherence to disease-specific guidelines, which usually do not consider multimorbidities (refer to Part A. Multimorbidity)

- concern about ceasing medicines that another prescriber started
- time constraints
- fear of drug withdrawal syndromes or disease relapse
- difficulty in conducting life expectancy/quality-of-life discussions.

## Shared decision making

All prescribers, patients and their family, pharmacists, nurses and allied health professionals are crucial components of deprescribing. It is important to explain to the patient that deprescribing is a positive intervention aimed at improving quality of life, and ensuring they do not receive unnecessary medicines with unlikely benefit or potential for harm. Individual potential risks, benefits and the withdrawal plan should be clearly explained, and patient or family concerns about deprescribing should be addressed.[1,15,18]

Patient involvement throughout the process is important to determine if care goals are being met and, if there are any adverse effects, medical practitioners should reinforce that deprescribing is part of an active treatment plan.

## Developing a deprescribing plan

Deprescribing involves:[1]

- assessing the patient to establish goals of care
- obtaining a comprehensive medication history
- identifying medicine/s that may be appropriate to cease
- prioritising medicine/s that should be ceased first
- developing a cessation plan
- monitoring and documenting outcomes after each medicine has been stopped.

### Step 1. Review all medicines

It is important to review all of the patient's medicines:[1,19,20,21]

- Review and reconcile medicines with other medicine lists, including those from a Home Medicines Review (HMR) or Residential Medication Management Review (RMMR), patient medicine list or discharge summary, with your current medicine list in your record.
- Check with My Health Record.
- Discuss any differences found with the patient, carer, RACF.
- Update the current medicine list.

### Step 2. Assess and discuss

Assess medicine-related benefits and risk of harm, and discuss options with patient, resident, family and advocate:[1,19,20,21]

- Consider
  - number of medicines used
  - high-risk medicines
  - past or current toxicity
  - patient/resident individual circumstances and preferences.
- Ask patient, resident, family and advocate if they are aware of, and understand, their options.
- Explain probable outcomes of continuing or discontinuing medicines, considering
  - patient's age

  - cognitive ability
  - dexterity problems
  - comorbidities
  - other prescribers
  - past or current adherence.

## Step 3. Assess and consider

Assess and consider the ongoing need for each medicine via the following steps:[1,19,20,21]

- Step 3A. Medicine adds no benefit, due to
  - toxicity
  - no indication
  - diagnosis no longer being appropriate
  - contraindication
  - cascade prescribing.
- Step 3B. Harm outweighs benefits
  - Is anticholinergic load high?
- Step 3C. Symptoms or disease medicines
  - Do guidelines suggest withdrawal after a period of stable disease?
- Step 3D. Preventive medicines
  - Is the potential benefit of the medicine unlikely to be realised because of limited life expectancy?
- Step 3E. Continue medicine
  - Check dose and monitor.

## Step 4. Prioritise medicines to be changed

Prioritise medicines that need to be changed by:[1,19,20,21]

- discussing, prioritising and planning any changes with patient, family and advocate
- asking them what they want
- deciding and agreeing on specific medicines to change, generally one at a time, slowly over weeks or months, in a stepwise approach.

## Step 5. Implement and monitor

Implement the plan and monitor the patient as follows:[1,19,20,21]

- Initiate the changes in collaboration with patient, family and advocate.
- Highlight any withdrawal syndromes and taper doses where appropriate (refer to Table 1).
- Monitor and check any changes associated with stopping the drug.
- Develop a medication management plan with the patient, family and advocate (refer to Part A. Medication management).
- Communicate the plan to the nursing staff, carers, accredited pharmacist, community pharmacy and your patient.

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