INNER EASTERN MELBOURNE DIVISION OF GENERAL PRACTICE LTD

NPS
National Prescribing Service Limited

Meeting Medication Minefields Midway

A clinical audit of Medication Review in Nursing Homes

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Background

- Polypharmacy most common in the elderly. [1]
- Medication review and simplification of meds minimise polypharmacy. [2]
- Med reviews in RACFs not universally accepted. [3]

References
1. Simons LA, Tett S, Simons J et al MJA 1992
2. NPS PPR Feb2000
3. Smith M , Pond D, Webster P and Acheson T 2001

Audit Aims

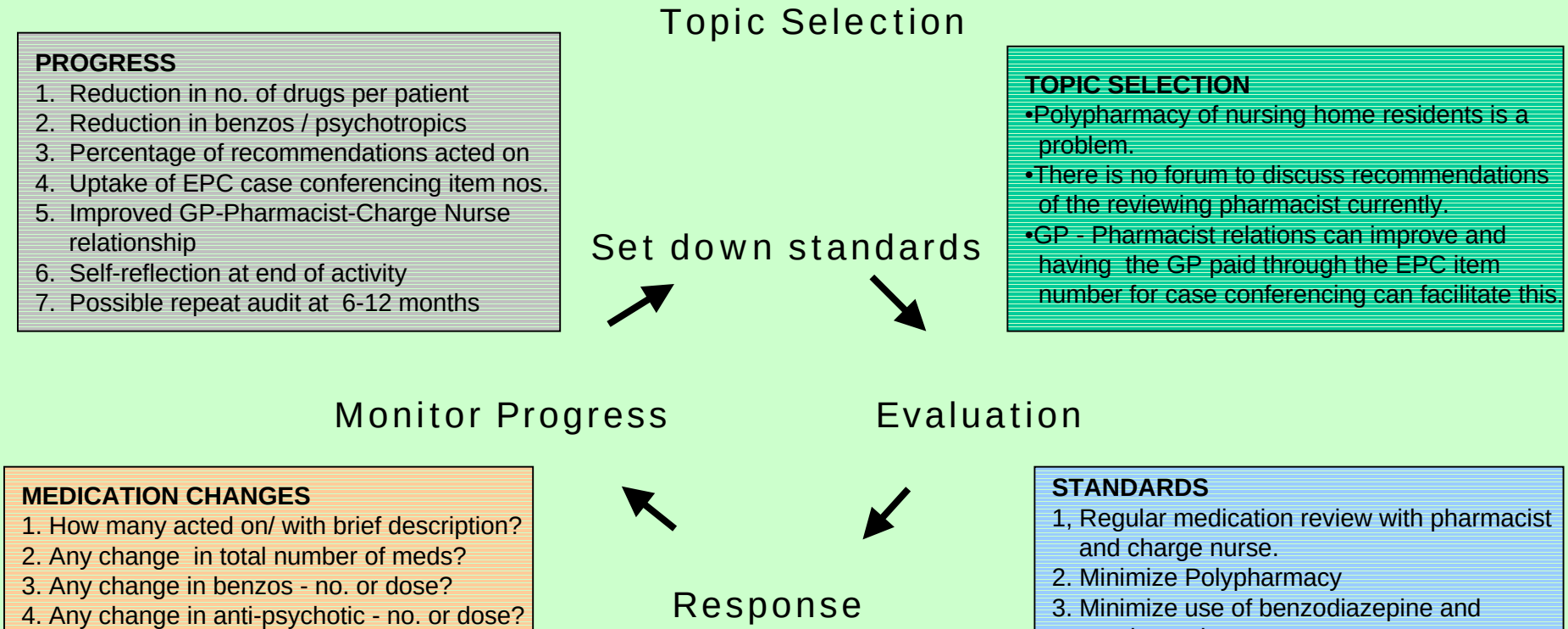
- Identifying & pre-empting possible polypharmacy situations.
- Identify any benzodiazepine & antipsychotic issues.
- Create an interactive environment between the team members.
- Provide an opportunity for self reflection about the usefulness of the review process.

Incentives and Time Constraints

- EPC case conference item number.
- RACGP approved.
- NPS approved.
- PIP payments apply
- Time involved 2½ hours
  - 10 patients @ 15 minutes for each review discussion
- Team : GP, Nurse Manager, Reviewing pharmacist.

The Audit

THE CLINICAL AUDIT CYCLE



PROGRESS
1. Reduction in no. of drugs per patient
2. Reduction in benzos / psychotropics
3. Percentage of recommendations acted on
4. Uptake of EPC case conferencing item nos.
5. Improved GP-Pharmacist-Charge Nurse relationship
6. Self-reflection at end of activity
7. Possible repeat audit at 6-12 months

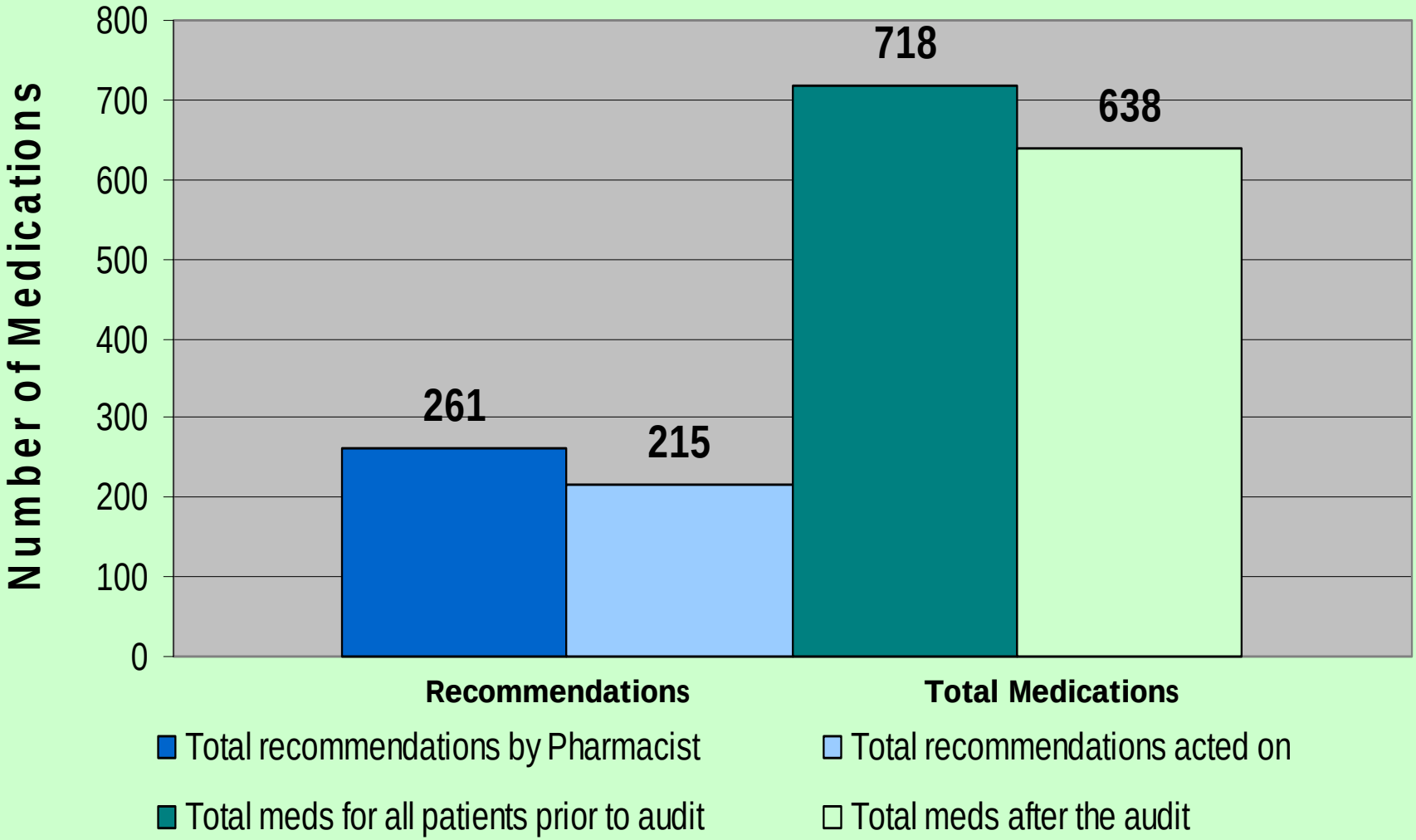
TOPIC SELECTION
- Polypharmacy of nursing home residents is a problem.
- There is no forum to discuss recommendations of the reviewing pharmacist currently.
- GP - Pharmacist relations can improve and having the GP paid through the EPC item number for case conferencing can facilitate this.

MEDICATION CHANGES
1. How many acted on/ with brief description?
2. Any change in total number of meds?
3. Any change in benzos - no. or dose?
4. Any change in anti-psychotic - no. or dose?

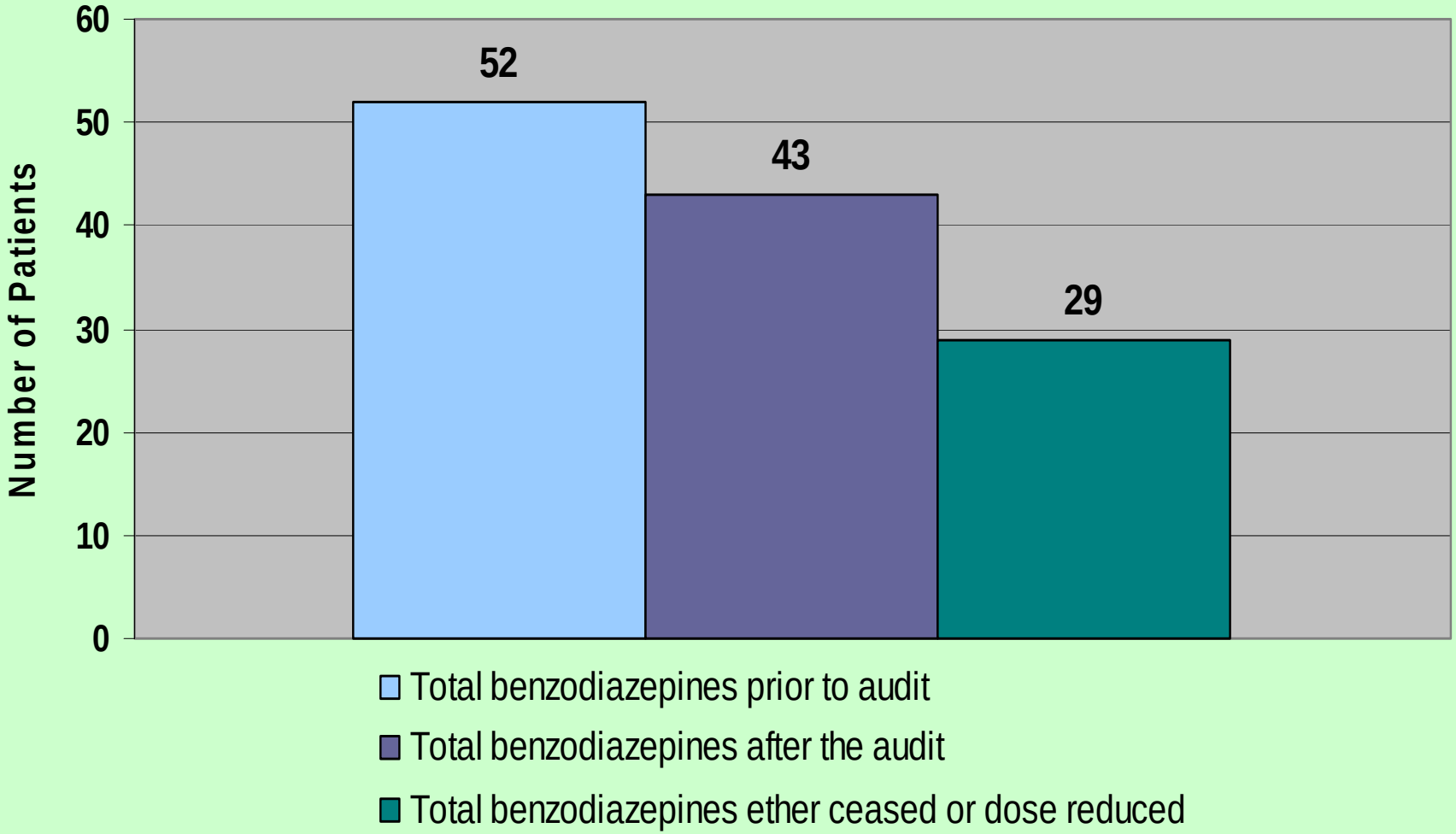
STANDARDS
1, Regular medication review with pharmacist and charge nurse.
2. Minimize Polypharmacy
3. Minimize use of benzodiazepine and psychotropics

PHARMACIST RECOMMENDATIONS
1. No. of pharmacies recommendations
2. Total number of meds.
3. Any benzos - no. doses?
4. Antipsychotics -no. doses?

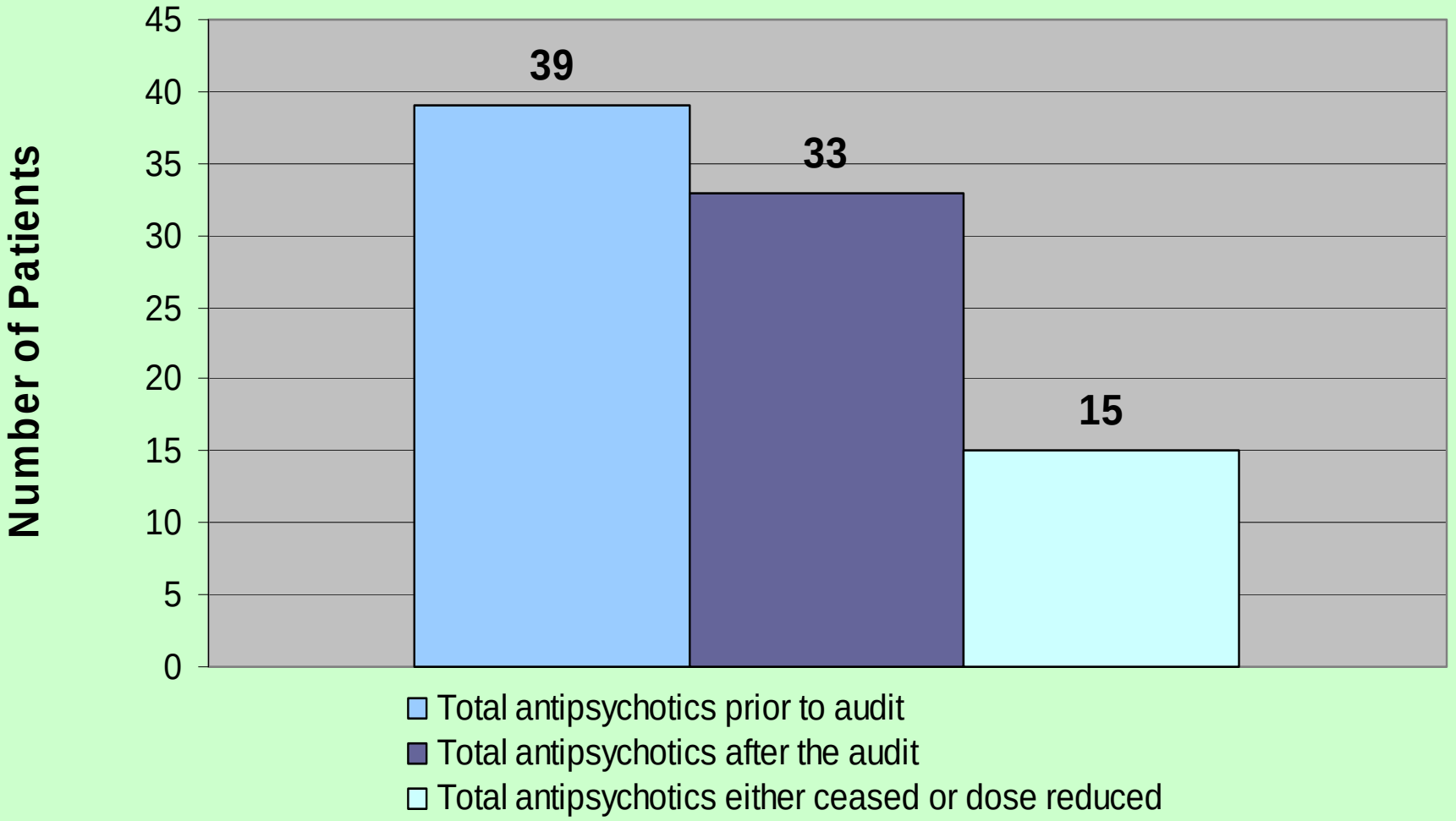
Recommendations and Total Medications



Benzodiazepines



Antipsychotics



Anecdotal Data

The GP Attitude to the usefulness of this process will be reported following collation of the questionnaire.

Anecdotal comments were:

- "It makes a huge difference to the relationship with the pharmacist. He is not just someone who rings up to tell me I've made a mistake."[i]
- " My GP's loved the process it enabled them to review treatment plans with the staff, within the medication context and gave me the opportunity to do some QUM education… I really enjoyed the experience of being part of a cohesive team"[ii]
- "My previous experience was infuriating the pharmacist just left a list of things I needed to change- with reference to my treatment plan or clinical intentions. Using a case conference with these patients made an enormous difference to the efficiency & effectiveness of the review "[iii]
- "It was very valuable to have the pharmacist *there* –I appreciated the advice and suggestions for managing a couple of issues- not just those relating to medication"[iv]

[i] Anecdotal report from verbal discussion Dr P, WA 12/11/02 [ii] Anecdotal report from verbal discussion between author and Mr GS pharmacist VIC 12/9/02 [iii] Anecdotal report from verbal discussion between author and Dr S Sunshine VIC 2/3/03 [iv] Anecdotal report from verbal discussion between author and D L Tomas town VIC 11/7/02

Our recommendations for improving best practice

To use an Enhanced Primary Care Case Conference Model to review medication management for patients in residential aged care facilities

Medicare Benefits Schedule Book 1 November 2002
ADAC Nov 2002