A study on deprescribing in palliative care patients to improve their quality of life by reducing the burden of unnecessary medicines.

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Background

There is a wealth of information on polypharmacy and deprescribing in frail and complex (F&C) patients, but little to support clinicians in deprescribing in palliative care patients where it could be argued there is the most potential for patient harm and waste of resources.

Most palliative care patients are elderly and therefore more likely to be receiving multiple drugs for existing comorbidities, resulting in an increased likelihood of drug interactions and adverse reactions.

Aim

The purpose of this project is two-fold:

1 – Quantitative data on palliative care deprescribing

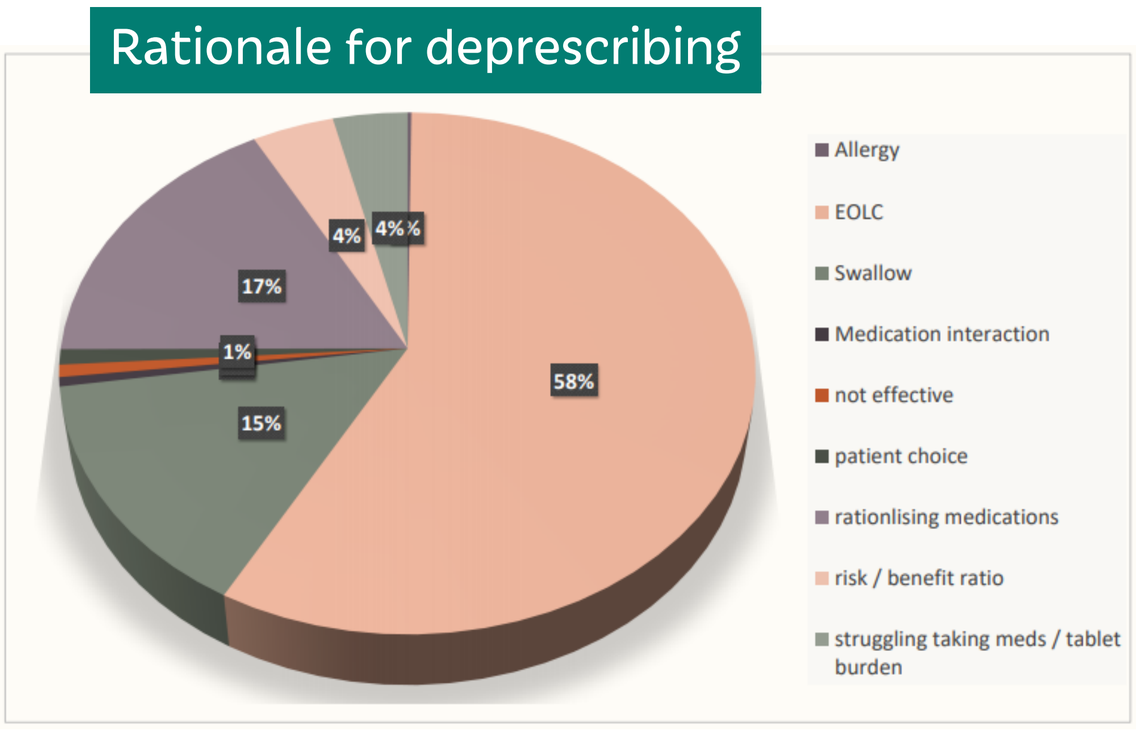
2 – Education and building a platform to facilitate deprescribing both within the hospice and extending this into the wider community

Methodology 1 (quantitative) based in hospice setting

Prospective data was collected from two hospice sites on the medications stopped, date and rationale over a three-month period. Medication kardex's of palliative in-patients had a proforma attached. The patient was followed until death. This prospectively gained a timeline of medication stops respective to date of death and rationale.

Results

Data was collected over a three month period, collating 647 medication stops of 208 differing medications of 112 different palliative patients. These were placed into 16 medication groups. These groups totalled 263 medication stops of 61 differing medications. There was an exclusion criteria of medications which could have been involved in symptom control and arguably confound the picture of true deprescribing, hence the numerical difference.



58% (361) medication stops were due to approaching end of life. 15% (93) due to swallowing difficulties, 17% (109) due to 'rationalising' medications.

"We are stopping preventative medications a median of four days before death once known to hospice palliative care."

So where do we go from here? Arguably, gathering data alone might inform practice but does not in itself bring about change without sharing the learning from this process.

Extending learning into the community

A workshop was held for GP practices and hospice NMPs to discuss the ethics, evidence and barriers to deprescribing, and consider the benefits for palliative care patients from deprescribing medicines to improve their quality of life. This was attended by GPs from ten of the 41 practices in Shropshire, and four NMPs.

100% of attendees

- Found the workshop helpful, open discussion on ethics, shared problems
- Agreed that when a medicine is unlikely to realise its potential benefit it should be stopped
- Agreed decisions to stop medicines which are not part of palliative care treatment should be made with the patient/family/carer

All de-prescribing should be considered a trial and medicines can be started again if necessary

Prescribers should consider stopping medicines that are no longer of real benefit to the patient. Examples of this might include:

- Medicines for primary prevention conditions eg statins, bisphosphonates, vitamins
- Medicines with important side effects eg NSAIDs causing GI effects, fluid retention
- Medicines for secondary prevention conditions where the NNT are high, or NNH are low, which reduces the patients' ability to benefit and increases the side effects profile e.g. statins, bisphosphonates, preventative DVT treatment
- Medicines where side effect/ adverse drug reactions are resulting in vortex prescribing (prescribing to treat the side effect of the first drug)

Conclusion

By outlining deprescribing current practice in palliative care we demonstrate the short timespan between deprescribing and death for medications arguably of minimal patient benefit at this point of life.

The rationale for stopping correlates with this postulation, outlining we are stopping the vast majority of medications due to the dying phase rather than pre-emptively.

Arguably, gathering data alone might inform practice but does not in itself bring about change.

We suggest that this study should therefore be seen as a positive step into identifying the need for a change in current practice, leading to future studies to outline how change is achieved and measured.

We fully appreciate the barriers to deprescribing early and hope in the future to try and give a robust evidence-based structure to allow clinicians to deprescribe with confidence.

Limitations

The lack of a robust audit tool in primary care makes collection of evidence of deprescribing difficult.

Time constraints in primary care make it difficult for prescribers to have meaningful deprescribing discussions with patients and families.

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here and at home