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Integrated Care Board

BSW Prescribing Guidance for Moderately to Severely Frail Patients

Frailty-Prescribing-Guidance-2.pdf (bswtogether.org.uk)

Dr Robin Fackrell, Associate Medical Director BSW ICB

Gayle Wynn, Pharmacist BSW ICB gaylewynn@nhs.net

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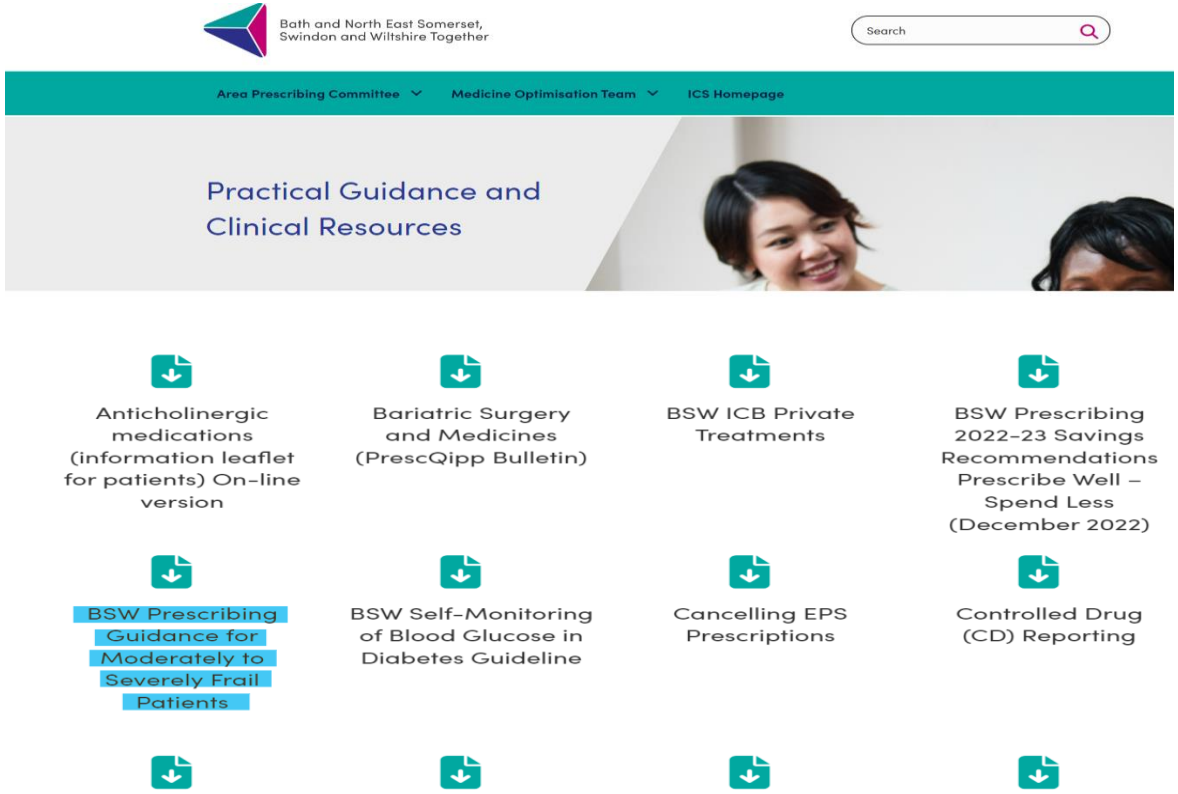
- https://bswtogether.org.uk/medicines/
  > Medicines Optimisation Team > Practical Guidance and Clinical Resources



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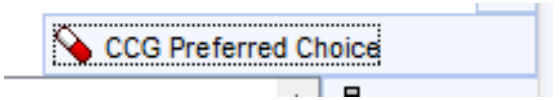
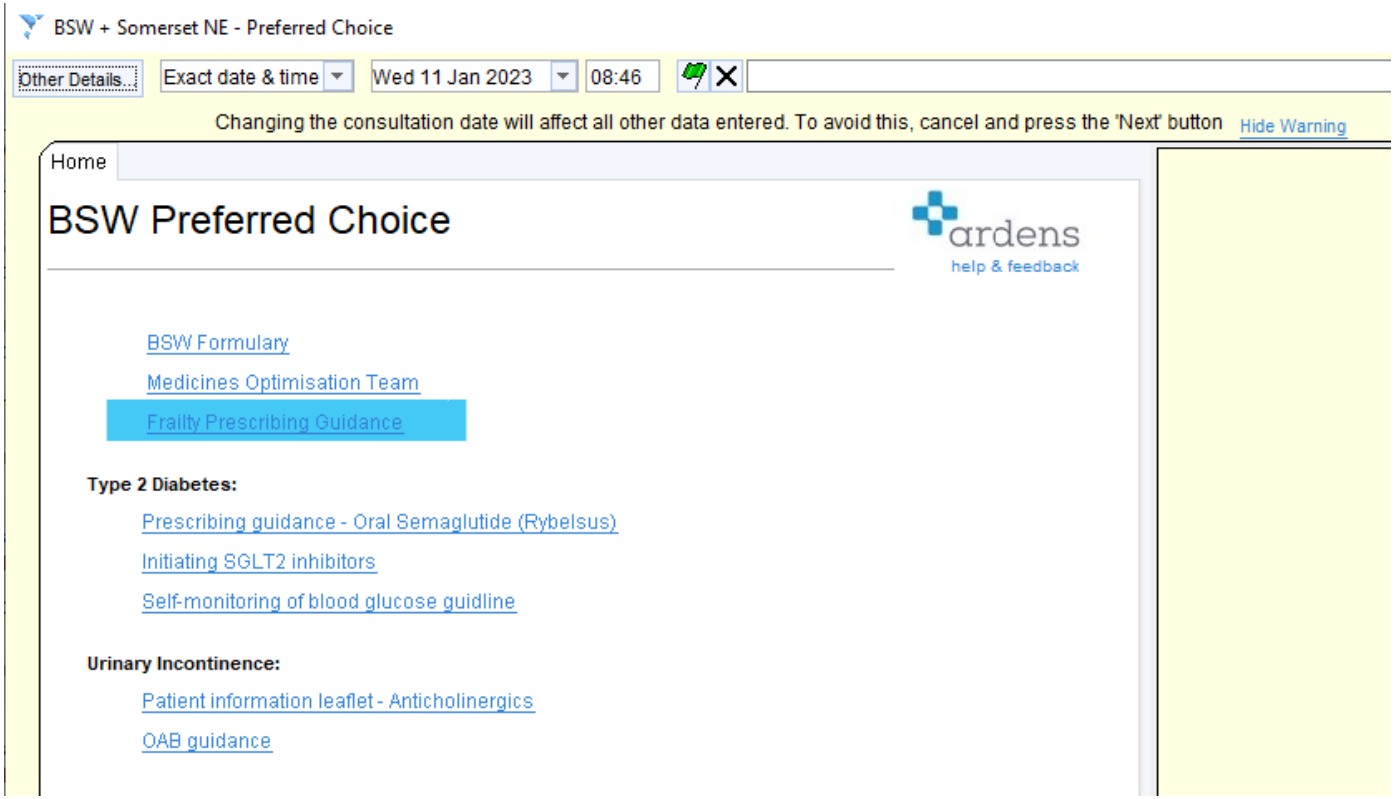
- Via Ardens Local/CCG Preferred Choice template





Prescribing Guidance for Moderately to Severely Frail Patients

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Severe frailty (Rockwood score 7-9): dependent for personal care. **Moderate** frailty (Rockwood score 5-6): need help with personal care.
If only **mild** frailty (Rockwood score 3-4) continue usual prescribing. Rockwood calculator: https://bit.ly/3LW27BJ

Deprescribing algorithms for specific drugs and further information in PrescQIPP IMPACT tool, available here: https://bit.ly/3rqjFw1

DIABETES Code as moderate or severe frailty for QOF		
Moderate Frailty	Aims	Control symptoms and avoid metabolic complications. QOF HbA1c target: <75 mmol/mol. Generally avoid HbA1c <60.
	Actions	If adjusting gliclazide/sulphonylurea or insulin dose, ensure BGLs are checked to avoid significant or symptomatic hyperglycaemia. Review Rx with renal function (e.g. avoid metformin if eGFR <30ml/min) & after change in care setting owing to changes in adherence & diet. Dietary restriction not appropriate if low BMI or losing weight.
Severe Frailty	Aims	Control symptoms and avoid metabolic complications. No "target" HbA1c. Stop routine monitoring unless clinical concern.
	Actions	De-escalate treatment where possible. Do not stop insulin in T1DM. Continue to monitor BGLs if on sulphonylurea or insulin.
HYPERTENSION Always measure lying and standing in >75yrs. Review after a fall.		
Moderate Frailty	Aims	BP <160/100 **&** no postural drop. Optimal BP for 75yrs+ may be 165/85.
	Actions	Avoid alpha blockers and thiazides
Severe Frailty	Aims	No BP target
	Actions	Stop anti-hypertensives
CHOLESTEROL REDUCTION		
Moderate Frailty	Aims	Primary prevention reduces CV risk if <75 yrs & no risk factors, or if <85 yrs with risk factors (particularly diabetes).
	Actions	If for primary prevention and not diabetic then stop Rx. If for secondary prevention (CV/stroke/PVD) or diabetic - continue.
Severe Frailty	Aims	No added value in the severely frail.
	Actions	Stop cholesterol drugs regardless of indication.
HEART FAILURE with reduced ejection fraction If normal NTpro-BNP consider other diagnosis		
Moderate Frailty	Aims	Symptom control & avoidance of hospital admission. Optimise Rx with loop diuretic (bumetanide has lowest ACB score) + ACEi/ARB + β blocker. NNT 15 to prevent one death/year.
	Actions	In confirmed HF, continue treatment as advised by specialist. Involve Community HF service. If not confirmed HF, consider titrating down diuretics & alternative causes of oedema eg dependency, amlodipine.
Severe Frailty	Aims	Continue Rx to reduce risk of terminal CCF.
	Actions	Manage symptoms, less concern regarding renal function. Continue ACE & diuretic even where BP is low, as long as not dizzy or syncope. Furosemide in syringe driver is an option at end of life.
ANGINA Refer/discuss if uncontrolled on 2 agents or first line treatments not tolerated		
Moderate Frailty	Aims	Usually fewer symptoms as mobility decreases.
	Actions	If asymptomatic or falling/hypotensive stop one drug at a time. Stop ISMN or Ca channel blocker first. Continue aspirin & statin.
Severe Frailty	Aims	Reduce & stop angina drugs; symptoms less likely if inactive/immobile.
	Actions	Stop aspirin and statin: NNT to prevent ischaemic event 250/year, and no significant reduction in mortality.

OSTEOPOROSIS		
Moderate Frailty	Aims	Prevent fractures. Calculate FRAX score for all.
	Actions	Prescribe oral bisphosphonates, or iv zoledronic acid, if age ≥70 and/or previous hip or vertebral #. Consider stopping after 5 years. Check tolerance at 12-16 weeks, and adherence yearly.
Severe Frailty	Aims	Immobility increases fracture risk, but no benefit in initiating anti-resorptive drugs in last year of life.
	Actions	Stop bisphosphonates if prognosis <1 year or if bed-bound. Do not stop or delay denosumab without a plan from specialist team.
OVER ACTIVE BLADDER See local guidelines: https://bit.ly/3yawG0M		
Moderate Frailty	Aims	Avoid anticholinergic OAB drugs, all have ACB score = 3. 2 year mortality: 20% with total ACB score ≥4 vs 7% with ACB score 0.
	Actions	Stop anticholinergics. If drug treatment needed use mirabegron. Refer for continence support.
Severe Frailty	Aims	Review need for any OAB drug.
	Actions	Avoid/stop drug treatment if significant functional or cognitive impairment; incontinent; catheterised; immobile.
DEMENTIA Consider referral to RICE/Old age psychiatry		
Moderate Frailty	Aims	Relieve symptoms, slow progression. Agree & document advanced care plans.
	Actions	Continue dementia drugs unless side effects > perceived benefits. Minimise anticholinergic burden (ACB) e.g. antimuscarinics, antihistamine, tricyclics. Taper & stop antipsychotics after 12 weeks if only for dementia. If physical aggression resumes, repeat weaning attempts at least yearly.
Severe Frailty	Aims	Minimise medication burden
	Actions	Continue dementia drugs if benefit to behavioural symptoms. Stop if side effects or unable to take e.g. unreliable swallow. Minimise other drugs to reduce risk of delirium.
ANALGESIA Usually not to exceed: Morphine 60mg bd; Fentanyl 25 mcg patch		
Moderate Frailty	Aims	Use lowest effective dose of analgesia - significant risk of side effects e.g. gabapentinoids & falls. Stop if cause of pain resolved e.g. post joint replacement in OA.
	Actions	**Regular** paracetamol first-line, continue if other analgesics added. Avoid amitriptyline as highly anticholinergic. Co-prescribe laxatives with opiates: stimulant + softener. Taper opioids when stopping e.g. 10% every 1-2 weeks. Avoid NSAID if possible, if no other option & eGFR >30: 2 weeks max, plus gastroprotection.
Severe Frailty	Aims	Titrate down analgesia to lowest effective dose and stop if able.
	Actions	Titrate down doses with weight loss. Titrate all drugs down if delirium. Consider pain or constipation as a cause of delirium.

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Guideline Development

- Frailty-specific guidelines
  - Gloucestershire CCG 2017 “Prescribing Guidance for Moderate to Severely Frail Patients”
  - Wiltshire CCG 2015 “Rational Prescribing”
- Polypharmacy guidelines
  - PrescQIPP IMPACT 2021
  - STOPP/START 2015
  - STOPPFrail 2017
  - Beers criteria 2019
  - Scotland Polypharmacy Guidance 2018
- Condition-specific guidance
  - QOF diabetes & hypertension
  - Bisphosphonate duration
  - Diabetes & frailty

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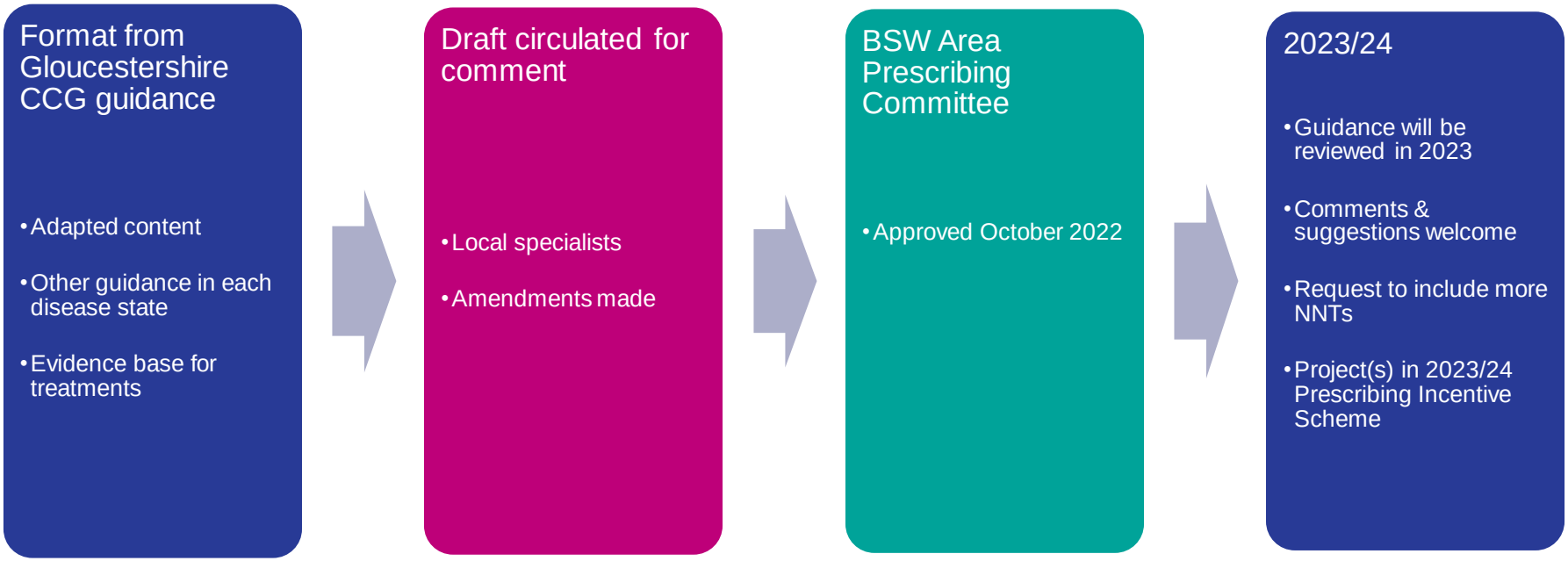
Guideline Development



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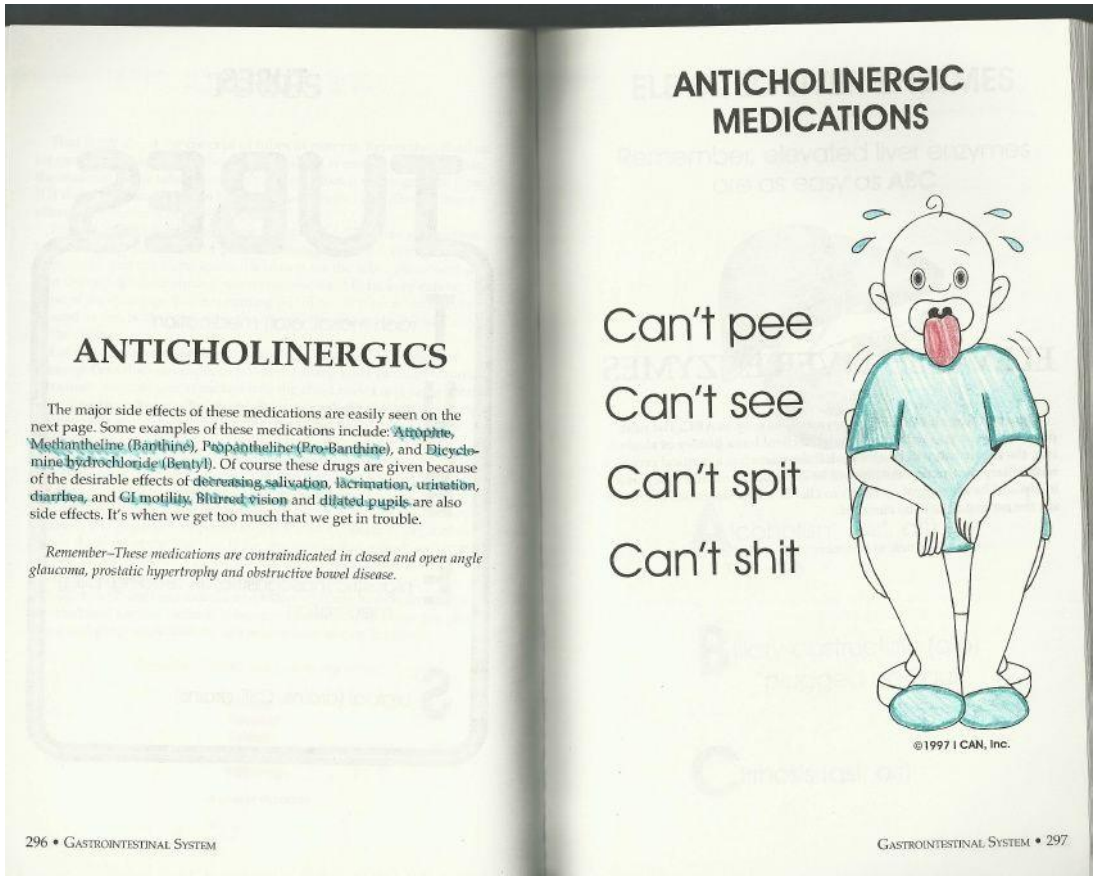
- Use in SMRs & LTC annual reviews
- Link to PrescQIPP IMPACT tool
  - Detailed guidance by BNF chapter
  - References
  - Deprescribing algorithms (need PrescQIPP log in to access)
- QOF exceptions where necessary: “Personalised care adjustment”
  - https://www.england.nhs.uk/wp-content/uploads/2022/03/PRN00027-qof-guidance-for-22-23-v2.pdf
  - Intervention described in the indicator is clinically unsuitable
  - There should be no blanket personalised care adjustments
- A guideline not a tramline
- ALWAYS in combination with Shared Decision Making

Deprescribing to prevent significant harm

Dr Robin Fackrell FRCP MA

Consultant Physician / Associate Medical Director, Ageing Well Programme, BSW CCG

Risks of anticholinergic medication



ANTICHOLINERGICS

The major side effects of these medications are easily seen on the next page. Some examples of these medications include: Atropine, Methantheline (Banthine), Propantheline (Pro-Banthine), and Dicyclomine hydrochloride (Bentyl). Of course these drugs are given because of the desirable effects of decreasing salivation, lacrimation, urination, diarrhea, and GI motility. Blurred vision and dilated pupils are also side effects. It's when we get too much that we get in trouble.

Remember–These medications are contraindicated in closed and open angle glaucoma, prostatic hypertrophy and obstructive bowel disease.

296 • GASTROINTESTINAL SYSTEM

ANTICHOLINERGIC MEDICATIONS

Can't pee
Can't see
Can't spit
Can't shit

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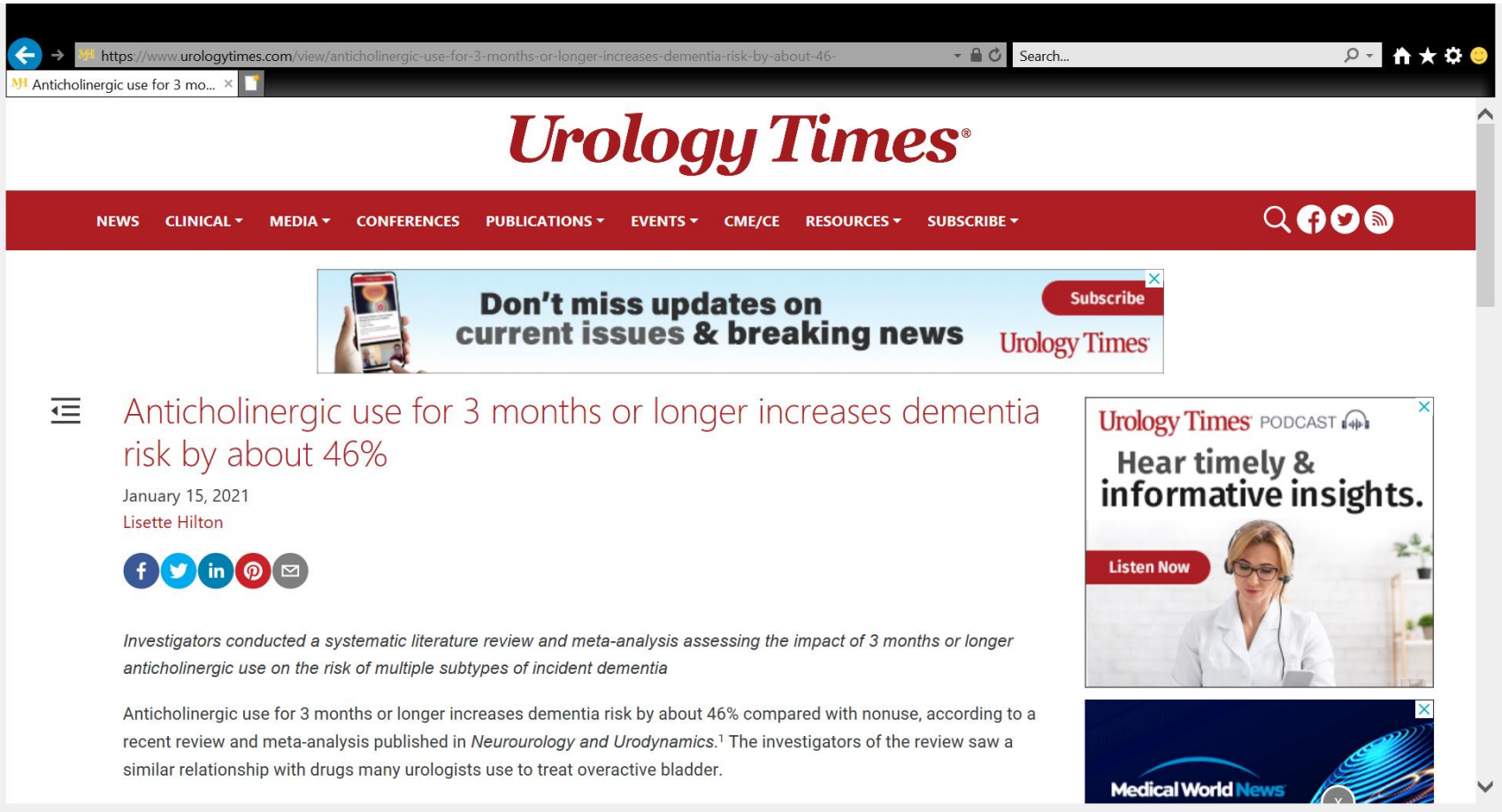
- ***Significant*** increase in:
- Dementia
- Death
- Falls (all types)
- Postural hypotension
- Dry mouth
- Hallucinations/Delirium
- Worsened glaucoma
- Constipation
- Urinary retention

JAMA Internal Medicine

JAMA Intern Med. 2019 Aug; 179(8): 1084–1093.
Published online 2019 Jun 24. doi: 10.1001/jamainternmed.2019.0677
PMCID: PMC6593623
PMID: 31233095

Anticholinergic Drug Exposure and the Risk of Dementia

A Nested Case-Control Study



Anticholinergic burden scale

Medications Possessing Anticholinergic Side Effects		
Mild	**Moderate**	**Significant**
Alprazolam	Amantadine	Amitriptyline
Atenolol	Cyclobenzaprine	Brompheniramine
Captopril	Carbamazepine	Chlorpheniramine
Diazepam	Meperidine	Clozapine
Digoxin	Oxcarbazepine	Diphenhydramine
Furosemide	Pimozide	Hydroxyzine
Haloperidol		Meclizine
Hydralazine		Olanzapine
Isosorbide		Oxybutynin
Loperamide		Paroxetine
Metoprolol		Quetiapine
Morphine		tolterodine
Ranitidine		
Risperidone		
Trazodone		

A note about statins

- What is the NNT in the >85 year old age group with no prior stroke or MI?

425

A note about anti-hypertensives

- **Blood pressure in frail older adults: associations with cardiovascular outcomes and all-cause mortality**
- Jane A H Masoli, Joao Delgado, Luke Pilling, David Strain, David Melzer
- *Age and Ageing*, Volume 49, Issue 5, September 2020, Pages 807–813,

A note about antihypertensives

- Large prospective observational study of 415,980 people above 75 years, inclusive of those often excluded from studies.

- The lowest mortality risk in adults above 75 years was at systolic BP 140–160 mmHg and diastolic of 80–90 mmHg.

- There was excess mortality in adults above 75 years with systolic BP <130 mmHg irrespective of baseline frailty.

- **In adults above 75 years with moderate to severe frailty and all above 85 years, there was no increased mortality risk with hypertension.**

A note about Tamsulosin

- A review of one Primary Care Network in BSW revealed that approximately 75 of their patients had a long term catheter and concomitant prescription of Tamsulosin…
- Tamsulosin in the context of LTC has no benefit at all
- The risk of orthostatic hypotension and falling however is high.

In summary

- What positive benefit is expected?
- What could the side effect profile look like?
- Remember trial data will **not** reflect the comorbid frail
- What are you trying to prevent and why?
- What does the patient want?
- Have they had **adequate counselling** and **informed consent**?
- Is there a built in review period?
- Can you be assured of concordance?
- We don’t put ‘Anticholinergic burden’ on death certificates but perhaps we should…

Upcoming AHSN Polypharmacy Events

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Booking link: [Community of Practice event # 3 - focus on ACB - 23rd February 2023]