Integrated Care System
Shropshire, Telford and Wrekin

NHS
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NHS Shropshire, Telford and Wrekin
Medicines Management

Structured Medication Reviews

Best Practice Guidance

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2	08/12/2023	Minor amendment to include more examples of medicines commonly associated with medication errors added on page 5

Contents

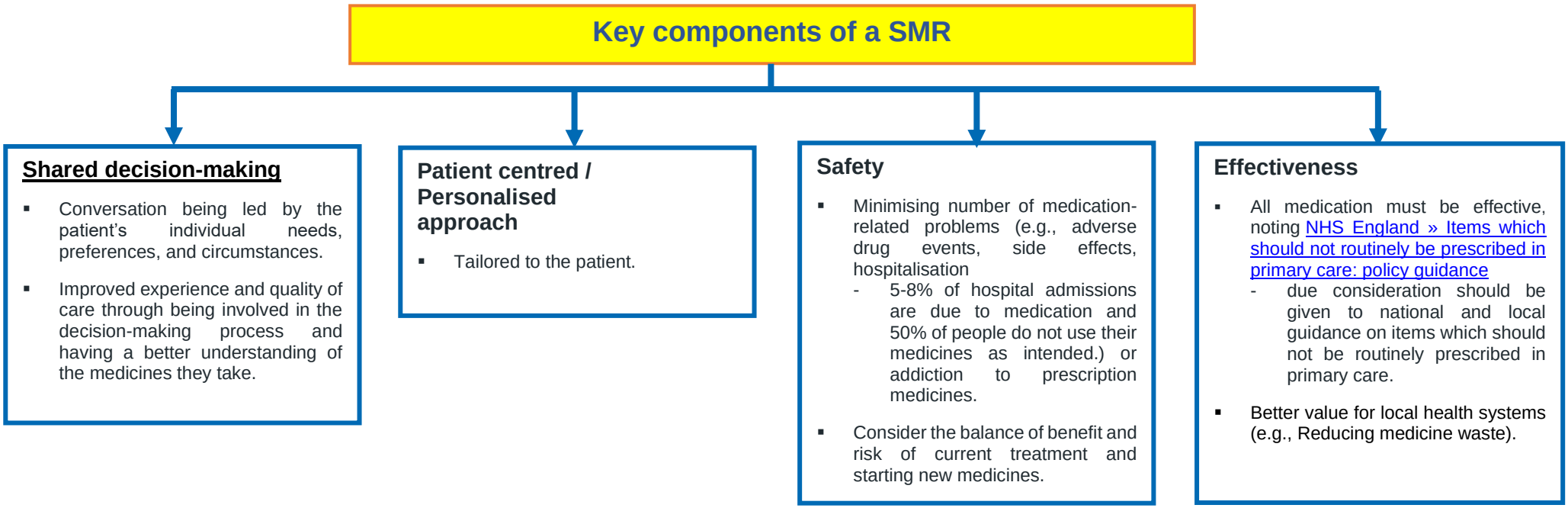
Structured Medicine Review (SMR)

IS:

- undertaken by only appropriately trained clinicians working within their sphere of competence. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills or be enrolled in a current training pathway to develop these. Although primarily it is clinical pharmacists that are expected to conduct SMRs, suitably qualified advanced nurse practitioners (ANPs) who meet the above criteria and can take a holistic view of a patient's medication, as well as GPs, can also do so.
- an evidence-based, comprehensive, and holistic review of a patient's medications, taking into consideration all aspects of their health, aiming to ensure that medications are prescribed for the right reason, the right amount and for the right time and are regularly reviewed to reduce the potential medication-related hospital admissions.
- optimising the impact of medications, minimising the number of medication-related problems, and reducing waste.
- where clinicians and patients work as equal partners to understand the balance between the benefits and risks of and alternatives of taking medicines.
- where prescribing is more complex (perhaps for some people with a learning disability or those at the end of their life), PCN clinicians undertaking SMRs should establish professional relationships and engage proactively with specialist pharmacists, consultants and other healthcare professionals working across the local healthcare system.

IS NOT

- the act of re-authorising repeat prescriptions.
- a review of some specific medicines during a long-term condition review, as a SMR consider all the medicines a patient is taking or using.
- considered complete until qualified consideration has been given to all the patient's medication; clinicians should be encouraged to collaborate with colleagues across the PCN and elsewhere, including acute care, and take a multidisciplinary approach to managing complex situations.



Prioritising patients for a SMR and Medicines Optimisation

- Patients in care homes
- Patients with complex and problematic polypharmacy, specifically those on 10 or more medications
- Patients with complex and problematic polypharmacy
  - Medications that can potentially cause dependency: e.g., opioids for pain-management, gabapentinoids
  - STOMP (stopping over medication of people with a learning disability, autism, or both with psychotropic medicines)
- Patients prescribed medicines commonly associated with medication errors, e.g.,
  - anticoagulants
  - opioids
  - antimicrobials
  - antidepressants
  - anti-convulsants
  - Insulin
  - Furosemide
- Patients with severe frailty, who are particularly isolated or housebound or who have had recent hospital admissions and/or falls

- Any other patients the PCN thinks would benefit, including those prescribed multiple but fewer than 10 medications:

At-risk groups e.g.

- prescribed higher risk medicines:
  - those associated with a high rate of errors e.g., Insulin, Anticoagulants
  - those requiring special monitoring e.g., Lithium
  - those with a wide range of side effects e.g., NSAIDs
  - those with a narrow therapeutic range e.g., Digoxin
- with high-risk conditions e.g.
  - COPD
  - Heart Failure
  - Diabetes
- with renal dysfunction
- with recent falls

- Optimising medications at end of life (e.g., prescribing & deprescribing)
- Abnormal biochemical markers where medications could be implicated
- Reduction of Health Inequalities
  core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)
  NHS England » Core20PLUS5 – An approach to reducing health inequalities for **children and young people**
  NHS England » Core20PLUS5 (**adults**) – an approach to reducing healthcare inequalities

Identifying patients for a SMR and Medicines Optimisation

Proactive Identification

Tools for finding patients:

- GP/Ardens local searches
- ECLIPSE SMR Live
- NHSBSA Polypharmacy Prescribing Comparator categories for your PCN and/or practice, Medication Safety Indicators /EPACT2
  Medicines optimisation - polypharmacy | NHSBSA
- PINCER
- Electronic Frailty Index (eFI)

Reactive triggers for a SMR

- Patient or care home self-referral
  - New Care Home resident
  - Recent discharge from hospital
  - Recent discharge from Virtual Ward
  - Recent discharge from other service e.g., OPAT [Outpatient parenteral antimicrobial therapy]
  - A patient or their carer raises concerns, e.g., ADR, not coping.
- Frequent hospital admissions
- Professional referral e.g., from community pharmacy, MDT meetings, home rounds

Structured Medication Review and Medicines Optimisation

SMR and Medicines Optimisation Flow chart

To be used as a check list

See NHS Shropshire, Telford & Wrekin Structured Medication Review Resources for some Polypharmacy decision aids

I First steps

Step 1	Contact Patient / Care Home	❑
Step 2	Agree who is going to attend	❑
Step 3	Agree whether the consultation is best done remotely or face to face	❑
Step 4	Agree a mutually suitable time	❑
Step 5	Ask **Care Home** to complete the **Structured Medication Review Request Form** [page 14] and email you prior to the person-centred Structured Medication Review consultation	❑
Step 6	Send **patient** a **Patient-Invitation-Letter**.pdf (thehealthinnovationnetwork.co.uk) **Me-and-My-Medicines-Charter**.pdf (thehealthinnovationnetwork.co.uk) **Are Your Medicines Working? patient checklist:** 03086 - GP Checklist Patient (No Crops) HIGH-RES (thehealthinnovationnetwork.co.uk) **Are Your Medicines Working? symptom tracker:** 03086 - Symptom tracker (No Crops) HIGH-RES (thehealthinnovationnetwork.co.uk)	❑

II Initial medication review without patient/carer

Step 1	Compare information provided on **Structured Medication Review Request Form** with GP Medical Record	❑
Step 2	What are the therapeutic objectives of each of the medications?	❑
Step 3	Which of their drugs are essential?	❑
Step 4	Biochemical/clinical targets: Required monitoring up to date?	❑
Step 5	Any continued need for non-essential drugs?	❑
Step 6	Cost-effective choice?	❑
Step 7	Other healthcare professionals involved in the patient's care?	❑

III Person-centred SMR consultation with patient and/or carer –

Personalised and tailored to the patient

Step 1	Concordance	❑
Step 2	Compliance	❑
Step 3	Does the patient have adverse drug reactions (ADR) or are they at risk of developing ADRs?	❑
Step 4	Are therapeutic objectives being achieved?	❑
Step 5	Unmet need	❑
Step 6	Acute illness	❑
Step 7	Lifestyle and non-medicinal interventions	❑
Step 8	Deprescribing	❑
Step 9	Follow Up planning	❑
Step 10	Address questions and ask if there is anything else they wish to discuss	❑
Step 11	Collect feedback A4-Patient-Survey-**Are-the-Meds-Working**-No-Crops-HIGH-RES.pdf (thehealthinnovationnetwork.co.uk) A4-Patient-Survey-**Me-and-My-Meds**-No-Crops-HIGH-RES.pdf (thehealthinnovationnetwork.co.uk)	❑
Step 12	Close the consultation appropriately	❑

IV Documentation and actioning changes on GP Medical Record

Step 1	Update the patient record on GP Medical Record	❑
Step 2	Read code	❑
Step 3	Communicate review to patient and the supplying pharmacy as appropriately	❑
Step 4	Audit	❑

Steps of Structured Medication Review and Medicines Optimisation

I First steps

Contact **Patient / Care Home** as appropriate with intention to review.

- explain the benefits of, and what to expect from a SMR
- Send **patient** a

Patient-Invitation-Letter.pdf (thehealthinnovationnetwork.co.uk)
Me-and-My-Medicines-Charter.pdf (thehealthinnovationnetwork.co.uk)

Are Your Medicines Working? **patient checklist**: 03086 - GP Checklist Patient (No Crops) HIGH-RES (thehealthinnovationnetwork.co.uk)

Are Your Medicines Working? **symptom tracker**: 03086 - Symptom tracker (No Crops) HIGH-RES (thehealthinnovationnetwork.co.uk)

Agree with Care Home priority patients (platforms include MDT & risk stratification).

Who is going to attend:

- Review Medication with patient (clarify if the patient has capacity to be involved), family member(s) patient advocate etc as appropriate and if possible key Care Home staff (obtain consent)
- Can the patient verbalise needs (e.g., Pain)?
- Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (e.g., using pictures, large print, patient leaflets).

Agree with patient / Care Home whether the consultation is best done remotely or face to face and agree a mutually suitable time:

- face to face where possible and in line with infection prevention and control, or
- remotely where deemed clinically appropriate e.g., telephone, Microsoft Teams call - Check technology is in place.

Ensure all the required information is available:

- Ask Care Home to complete the **Structured Medication Review Request Form** [Page 14] and email you prior to the person-centred Structured Medication Review consultation.

II Initial medication review without patient/carer

Reviewing the following topics before seeing patient and/or carer might save time:

Review the information patient and/or carer / Care Home provided on Structured Medication Review Request Form and compare with GP Medical Record: Are there any changes from previous recordings?

- Medicines reconciliation:
  - Compare current medications on GP medical records with the current list in use:
    MAR sheet, including any OTC or complementary medications.
  - Receiving medications from more than one source e.g., specialist and GP?
  - Are there clear prescription instructions?
    When (at the right times) how and why to take the medication?
    For how long?
  - Are there clear warnings instruction about the risk of burns with emollients?
    Risk of severe and fatal burns with emollients (regardless of paraffin concentration)
- The patient is compliant with their treatment? – from MAR chart.
  - Reasons for poor compliance should be explored in the consultation.
- Does Allergies status on referral form correspond to GP system record?
  - Ascertain nature of allergy, especially in regard to antimicrobials
- Key observations: Any changes to previous records and compared to patient's usual baseline? How up to date are they?
  - Consider risks of medication e.g., falls risk, cognitive deterioration.
- How is diet, fluid intake? Potential swallowing issues?
- Continence status?
- Mobility/weight bearing and falls status?

What are the therapeutic objectives of each of the medications?

- Indications:
  - To manage existing health problems? To prevent future problems? Is that recorded in the patient's GP Medical record?
- Consider appropriate duration of treatment.
  - Was long term therapy intended?
- Is it appropriate? Is it still indicated? Any contraindications?
  - Any change in patient factors such as e.g., kidney function or co-morbidities?
- Are dose and dosing schedule appropriate / evidence based?
  - The dose prescribed appropriate with advancing age or changing physiology e.g., renal clearance?
  - Over or under-treatment?
- To reduce antimicrobial resistance (AMR): long term antimicrobial prescribing still appropriate?
- Where clinically appropriate: lower carbon alternatives inhalers?

Which of their drugs are essential?

- Essential replacement function e.g., thyroxine
- Prevention of rapid deterioration e.g., drugs for heart failure, epilepsy etc

Biochemical/clinical targets

- Required monitoring up to date? Any required arrangements in place?
  - Depending on the prescribed treatment, specific laboratory markers may require regular monitoring to assess clinical effectiveness and to identify patient safety risks of possible ADEs (e.g., hypokalaemia).
  - Follow up the results.

Any continued need for non-essential drugs?

- Any drugs only intended for temporary use?
- Higher than usual maintenance doses?
- Evidence-base for benefit? e.g., poor evidence of efficacy, high NNT
- Limited benefit to that patient?

Cost-effective choice?

- Prescribed within NICE guidance and the Local Health Economy Netformulary?
- Any possibility of safe generic substitution?
- Nationally identified medicines of low priority / limited clinical value?
- Minimising waste in prescribing?
  - The quantities should be standardised to 28 days or multiples of 28 days.

Other healthcare professionals involved in the patient's care?

- Tissue Viability Nurses, District Nurses, SALT, Dietitians, Mental Health Services, Physiotherapists etc

III Person-centred SMR consultation with patient and/or carer - Personalised and tailored to the patient

Concordance

- **Shared decision-making** principles should underpin the conversation.
  - What would the patient like to get from a SMR?
  - How would the patient like their medicines to support their quality of life moving forward?
  - Does the patient understand the rationale behind their treatment?
  - What are their treatment goals?

Compliance

- **Is the patient willing and able to take the medication as intended?**
  - What medicines (prescribed, OTC or complementary medications) is the patient taking / not taking and why? Patient opinion, objective evidence; see shared decision making above.
  - "**As required**" medication: determine if the patient and/or carer know how and when it should be taken.
  - Any **swallowing difficulties**?
  - Any **cognitive challenges** for patient? Memory problems: Consider Medication Reminder Chart.
  - Any **visual impairment**? Consider advising community pharmacy: large print labels, colour coding etc.
  - Any **dexterity problems**? Consider advising community pharmacy: large containers, easy open tops, pill press, eye drop dispensers etc.
  - **Time critical medications**: Parkinson's, Diabetes and Epilepsy: at the right time every time?
- **Medications in most convenient form and dosing schedule?**
  - Any technical challenges? e.g., inhaler technique
  - Consider pill burden e.g., multiple daily doses: reducing frequency of daily administration?
- **Are side effects a problem?**
  - Altering timing of medicines perhaps helpful?
- **Reordering repeat medications?** Synchronise in repeat cycle.

Does the patient have adverse drug reactions (ADR) or are they at risk of developing ADRs?

- **Drugs most commonly implicated with ADR**: Diuretics, Steroids, PPIs, Antiplatelets, ACE/ A2RB, Opioids
- **Some ADRs may occur as a result of one or more contributing factors:**
  - Drug-drug interactions
    - cumulative adverse drug effects from multiple medications that cause the same adverse event, e.g., anticholinergic burden in the frail [See NHS Shropshire, Telford & Wrekin Structured Medication Review Resources document for links to some websites to work out the Anticholinergic Burden for your patients]
  - Drug-Disease interactions
  - Drug–Patient' interactions
- **Risk of accidental overdose?**
- **Any possible therapeutic cascade?**
  - Where ADRs caused by other medications are misinterpreted as a new disease and treated with new medication (prescribed or OTC).
    - → OTC medicines could interact with prescribed medicines or adversely impact on clinical condition e.g. NSAIDs in CV disease or renal dysfunction
  - Common ADRs that are often not attributed to medication include confusion, constipation, hypotension, and falls.
  - Is there any other risk of harm due to co-morbidities (high risk medicines, drug interactions, contraindications)?
- **Are these side effects excessive when weighed against the benefits of the medicines?**
  - Safety – consider the balance of benefit and risk.

Are **therapeutic objectives** being achieved?

- **Are long term condition(s) / Symptoms well controlled?**
  - Preventing disease progression/exacerbation?
- **Does the patient have an identified indication that is not being treated optimally?**

Unmet need

- This is **an opportunity to identify new conditions**, particularly those that increase in prevalence with age, e.g., Atrial Fibrillation
- Should anything be added to treatment?
  - The additional treatment has the potential to further complicate the patient's clinical picture!
  - Upon initiation of a new medicine and on regular medication review, patients and/or their carers should be made aware of the likely ADEs to look out for, and they should know what to do if they experience them.

III Person-centred SMR consultation with patient and/or carer - Personalised and tailored to the patient

Acute illness

- Any changes to medications needed?
  - Do you need to explain sick day rules to help minimise admissions for acute kidney Injury?
  - Stop the 'DAMN' drugs in intercurrent illness associated with dehydration.
    Sick Day Rules – Effective Prescribing and Therapeutics (scot.nhs.uk)

Lifestyle and non-medicinal interventions

- Have evidence-based alternatives to a medicine been considered / utilised, e.g.
  - physiotherapy,
  - talking therapies or
  - local social prescribing options?
- Have lifestyle interventions that complement pharmacological therapy promoted as appropriate?

Deprescribing - ensure the safe and effective withdrawal of inappropriate medications where indicated:
[See NHS Shropshire, Telford & Wrekin Structured Medication Review Resources document for some Polypharmacy decision aids]

- A one-at-a-time approach should be adopted to monitor benefits or for any return of symptoms.
- To reduce the likelihood of an adverse withdrawal event, some therapies should not be stopped abruptly following long-term use.
  - Withdrawal will take longer for drugs with a long half-life.
- Consider the impact of withdrawing an interacting drug
  - e.g., warfarin and naproxen
- Tapering may be required with opioids, antidepressants, antipsychotics, anticonvulsants, centrally acting antihypertensives, corticosteroids, hypnotics, and tranquilisers.
- Some of these medicines may require specialist input, depending on the indication for prescribing.

The final decision to prescribe or de-prescribe must be based equally on
- the clinical evidence
- the prescriber's experience
- the patient's values, experience, circumstances, and preferences

Has the patient been provided with appropriate information to make an informed decision about the medicines they will take after the SMR appointment, together with a clear record and plan?
  - Provide list of red flags to prompt rapid action.

Provide safety- netting information and signpost for support as appropriate.
Stopping-your-Medicine-Guide.pdf (thehealthinnovationnetwork.co.uk)

Follow Up planning

- Agree how treatment and medication changes will be monitored after the SMR appointment.
- Determine the number of follow-ups needed in partnership with the patient, family member(s), Care Home staff etc as appropriate; this will depend on complexity.
  - to ensure the safety and effectiveness of any interventions
- Set a date for the next SMR review, with consideration given to the duration of initial and repeat prescriptions, and whether electronic repeat dispensing would be beneficial; particularly for medicines known to cause dependence and withdrawal.

Collect feedback
A4-Patient-Survey-**Are-the-Meds-Working**-No-Crops-HIGH-RES.pdf (thehealthinnovationnetwork.co.uk)
A4-Patient-Survey-**Me-and-My-Meds**-No-Crops-HIGH-RES.pdf (thehealthinnovationnetwork.co.uk)

Address questions and ask if there is anything else they wish to discuss.

Terminate — Close the consultation appropriately.

IV Documentation and actioning of consultation outcomes

Update the patient record and document the review in the patient's notes on GP Medical Record.

- Consultation notes should be contemporaneous and demonstrate that you are working within your competencies.

- Records should contain information including:
  - uptodate allergy status,
  - accurate problem lists and summaries,
  - documentation of clinical findings,
  - documentation of uptodate key observations
  - investigations requested,
  - Regular' and 'When Required' Medicines
    - Reconciled in line with current national guidance.
    - Appropriately prescribed and monitored.
    - Prescribed medicines that need specific monitoring highlighted.
  - A summary of the findings of the review,
  - Implemented changes:
    - Medication changes implemented by the prescriber.
    - Information pertinent to any decisions made.
    - The information provided to the patient on risks and benefits and the patient's informed decision.
  - management plans,
  - safety netting,
  - referrals and
  - follow-up / next Medication Review.

- Document any external software utilised to support SMR e.g., Eclipse, EPACT2 etc.

- **Patients' records should be coded appropriately to ensure their care is delivered effectively**.
  Read code:
  - appropriate to the review
  - Care Home patient, Heart Failure, COPD, Learning Disability etc.
  - Reasons of hospital admission
  - Treatment check and optimisation
  - Compliance and concordance check
  - Side effect and interaction check
  - Monitoring check

- **Complete appropriate Structured Medication Review templates**
  - use the SMR SNOMED code (Delivery of structured medication reviews) to record each time a patient is seen for a SMR (including follow up).
  - The applicable SNOMED codes are available in the relevant business rules published by NHS Digital under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

- **Organise a follow-up and task a follow-up, if needed.**
  - The impact of any changes should be monitored.

- **Communication**
  - Communicate the review outcome to patient and/or carer if a Care Home resident.
  - Inform the nominated dispensing pharmacy of medication changes.
  - If the patient needs compliance aids, please refer to the nominated dispensing pharmacy for assessment.

  - Communicate e.g., via NHS.net [Add a read receipt to email to ensure home receives written confirmation of the Review document].

  - Include information pertinent to any decisions made e.g.:
    - formulary drug choices and rationale,
    - duration of treatment,
    - the changes made to current medication and rationale,
    - when to stop medications e.g., ONS products,
    - advice given e.g., safe administration,
    - safety- netting information as appropriate,
    - further monitoring/investigations,
    - review action plan,
    - follow up as appropriate.

- **Audit**
  - Practices and Medicines Management team can audit the recorded SMRs.

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Polypharmacy and medicines optimisation | The King's Fund (kingsfund.org.uk)

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British Journal of Nursing - Undertaking consultations and clinical assessments at advanced level

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Structured Medication Review Request Form

Section 1: Referral Details

Resident		Date of birth	
Care Home		GP surgery	
Referrer		Date	

Section 2: Reason for referral

Deterioration	Physical	☐ Yes	☐ No	Cognitive	☐ Yes ☐ No
Recent Hospital discharge		☐ Yes	☐ No	New admission	☐ Yes ☐ No
Recent Virtual Ward discharge		☐ Yes	☐ No		
Difficulty taking medication e.g., refusals, adherence issues					
Further comments/concerns					

Section 3: Medications

Please submit a copy of the resident's **Medicines Administration Record** and any other medicines related documentation with this request.
Including prescribed, homely remedies, over-the-counter medicines, Self-care, complementary and alternative medicine.

Please state any queries or concerns with this resident's medicines here:

Section 4: Key information (Please provide relevant UpToDate details)

ReSPECT plan in place? ☐ Yes ☐ No Date of plan:	ACP [Advance Care Planning] in place? ☐ Yes ☐ No Date of plan:
Mental Capacity: Please provide relevant details.	
Allergies - Nature of allergy	

Sight Impairment?	☐ Yes ☐ No	Hearing Impairment?	☐ Yes ☐ No

Screening	Result		Date of assessment	Changes compared to patient's usual baseline
Blood pressure	Lying	mmHg		
	Siting	mmHg		
	Standing	mmHg		
Heart rate		bpm		
Oxygen Saturation		$\%O_2$		
Respiratory Rate		rpm		
Breathless	☐ Yes ☐ No			
Smoking		/Day		
Oedema	☐ Yes ☐ No			
Weight		Kg		
Diet intake				
Fluid intake				
Swallowing difficulty	☐ Yes ☐ No			
SALT referral complete	☐ Yes ☐ No ☐ N/A			
MUST score				
BMI		Kg/m^2		

					Please provide the date of assessment and if any changes compared to patient's usual baseline
Bladder (please tick)	☐ Frequency	☐ Incontinence	☐ Retention history	☐ Catheter	
Bowel (please tick)	☐ Normal	☐ Incontinence	☐ Diarrhoea	☐ Constipation	
Mobility	☐ Independent	☐ Stick/frame	☐ Hoisted	☐ Bedbound	
Risk of Falls	☐ Low	☐ Medium	☐ High		

Practice use only –
Ensure that the following and all the relevant clinical codes are input to the patient's medical record e.g.,

Structured medication review (procedure)	**1239511000000100**
Discharged from hospital (finding)	**183665006**
Lives in care home (finding)	**248171000000108**