ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Evening Medical Update: Mastering Medicine of the Elderly
November 2020

Polypharmacy: Balancing medications in frail adults – Dr Martin Wilson

What are your views on when when/how to reintroduce medicines once a patient is discharged, assuming that the chronic condition is causing problems/still present?
I think this question relates to the situation where medication for a chronic condition is stopped due to an inter-current illness e.g. a cut back in BP medication if the patient's illness drove down there blood pressure. In that case important it is indicated on discharge letter the intention was to *restart* when patient feeling back to normal (eating, drinking and feeling better.) An estimate on this can be made in some case but will sometimes need passed to GP e.g. ask patient to get BP check in 2 weeks.

Polypharmacy – I would make this knowledge mandatory in all training, it is so vital. I do not see much improvement, how do we get this message through?
The surge in number of medications available for treatment has been dramatic over the past 2 decades. It will take similarly long to get understanding of how to wisely use these medication. At present Polypharmacy training part of all Pharmacist training courses in Scotland, most medical schools (and on EMU updates!) This is backed by a national guideline. That sounds a lot, but as you say it takes a long time for the concepts to feel embedded as standard practice. I am afraid it will just take time. It will occur though. If there is a lot of anything about, we do eventually get good at managing it.

When enquiring about what matters to a patient when rationalising medication – how can we not leave out medication that is really necessary, but not part of what the patient wants?
Depends a little on the scenario. This sounds to be mostly around understanding. The situation sounds to be the adult does not want to take a highly effective medication because it is not part of their current priorities. Main task then is to ensure as far as possible what the medication(s) are expected to achieve. If they still feel is not something they do not want then do not prescribe (as really then becomes a consent issue: - the main factor is ensuring it is *informed* consent (or dissent).

How common are unwanted adverse effects from stopping medication? And how do we know? Is it not better to go slow?
To be clear the medication review done in the presentation was markedly compressed to allow the concepts to be got across in the period of a talk. In practice stop immediately anything that is likely to cause immediate harm (as listed in presentation e.g. combination blood thinners for no active reason, very low BP for anything other than LVSD.) Most other things are best done bit at a time to build confidence and make it clear what did what if things go wrong. Stopping can go faster in hospital (and often does as usually some sort of crisis accelerated the need for change.)

Sometimes there are too many hands on the prescribing pad – how do we avoid one subtracting and the other adding without ever talking to each other?
That relates to a big topic about interaction between all the multiple agencies: primary care, secondary care, OOH and host of subsets in each. Best one can do is document clearly and try and ensure patient understands (so they can ask questions too.) I copy letters to patients a lot from OPC to try and help with this. There is never an issue with someone else reversing a change as long as they understand why it was done in the first place.

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Hospital at home and community care for the elderly – Dr Patricia Cantley

How has the Hospital at Home been operating during the COVID-19 crisis? How can the Hospital at Home be expanded?

To be honest, we've really just been operating in the same way as usual – though with a bit more Personal Protective Equipment. We were quiet for a while, but even more patients than usual want to avoid a conventional hospital admission, so when they ask their GP if they can stay at home, we get a call. We've seen a bit of COVID, both in care homes and in the general population – though if someone is very unwell and for full supportive treatment, we usually send them in to the main teaching hospital.

In terms of expanding – we'd love to, and that is part of the Scottish Government's plan. Also more locally, Midlothian Health and Social Care Partnership is working with us to see what we could do more of. One of the key challenges though is for the patients that need help with personal care – if they don't already have that in place. We can't always access it when we'd like to, though we do have a Social Care step up/step down unit that we can admit people to.

Could Hospital at Home be the answer to providing care for patients unable to attend the Emergency Department due to the COVID-19 crisis – especially the elderly?

Yes, this is very much part of our plan going forward and we're part of an initiative called "Home First" across Lothian that will be looking at exactly that. Though it does depend a lot on whether the person's care needs can be met at home. In the future, we'd also like to investigate more what can be done using Point of Care radiology as well as blood tests.

Could Hospital at Home be used to provide additional support to care homes especially where residents may need referral to the acute setting for acute care?

Yes – very much so. I don't know the exact numbers, but we see quite a lot of care home residents. In many ways they are perfect for Hospital at Home, if their care needs are already met in the care home. We have a system in place at the moment where the Scottish Ambulance Service can refer to us directly if they wish to, for any care home resident.

Could the Hospital at Home also operate alongside acute admissions during times when Emergency Departments are overwhelmed with patients such as the winter pressures?

I'm not sure I completely follow the question as we try to do this all year round. When the Emergency Dept is very full I think the GPs do think about us a bit more, but we're keen to help regardless of whether they are busy or quiet. The main risk when they are busy is that they make a quick decision for admission – but we are hopeful that they can offer H@H as an alternative and if the family and patient are happy, then we will sort out the rest once the person is home.

How often do patients/relatives have to call for help out of hours?

Very rarely, interestingly (sorry I don't have numbers) – and when it is, it's usually for an unrelated problem. It's interesting how many people can cope until 8am the following morning if they know that they can ask a question or get help then.

What about healthcare workers' safety with Hospital at Home? Are there any risks or reported events of violence from patients or relatives?

This is a good question – and one that those of us who were used to working in Secondary Care had to get used to. Every situation is assessed for risk, both formally and informally. We often visit in pairs, and would almost always do a first assessment in twos. Our administrator knows where everyone is at any time and phones to check on people if they aren't back at base as expected. We've never had a problem – but that's not a reason to be complacent. As a

general rule – families are very happy. If they don't want the person at home, then we explore what the issues are, and whether the person themselves has the capacity to make that decision.

How do you plan a patient's discharge? Is there planned follow-up in collaboration with primary care?
The discharge is planned primarily with the patient and their family. We will often give them a bit of warning that "if your blood tests are OK tomorrow, then we'll discharge you". The last visit is usually done by a trained member of staff so that they can do a full Medicines Reconciliation with the patient. If we need to liaise with the local Pharmacy (for example if they have a blister pack) we make sure all of that is sorted prior to the discharge.

The patient gets a letter on discharge with a contact number in case they have questions, and this is followed up with a copy of their discharge letter within 24 hours. This is also immediately sent to the GP electronically and (we like to think) is of a high standard so that they know what's going on. That probably sounds a bit boastful – but the final communication is perhaps one of the most important things that we do, so we do focus on it a lot. All discharge letters are double checked for both "silly" mistakes and also any other discrepancies.

For any patient with a significant new diagnosis, such as dementia or cancer, we would usually make a more personal contact with the GP, using the practice's Clinical Inbox which is always monitored, asking if someone can call us to discuss the story.