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Application of STOPPfrail Tool to Residents of an Approved Residential Unit for Psychiatry of Later Life

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Sir,

Polypharmacy is a common issue in the elderly population[1] There is a direct relationship between increase in polypharmacy and inappropriate prescribing. This high medication burden can have negative consequences such as increase rate of adverse drug reactions, increased morbidity and mortality and economic cost.[2] Therapeutic goals may also change over time because of increasing frailty and shortening life expectancy. Physicians are often reluctant to deprescribe for many reasons including fear of adverse outcomes, fear of litigation, lack of knowledge, time constraint and lack of guidelines.

We recently conducted an audit on current inpatients in an Approved Centre for Psychiatry of Old age using the STOPPfrail tool (Screening tool of older person's potentially inappropriate prescriptions in frail older adults with limited life expectancy)[3]. For each patient the total number of regular medications was noted. The need for each medication was then scrutinised by a panel of three including consultant Psychiatrist, GP trainee and CNM. Inappropriate medications were then stopped. One month later the charts were reviewed, and the number of medications restarted was recorded. The Criteria was reapplied to assess number of inappropriate medications. The standard set was that no inappropriately prescribed medications, according to the STOPPfrail tool, should be prescribed.

A total of 15 inpatients met the inclusion criteria for the audit. Of these 10 were male and 5 were female. The mean age was 79.2(±7.62) years. Total number of medications prescribed was 159 with a mean of 10.6 (± 4.84). The maximum number of medications for one patient was 21. A total of 53 medications were stopped on the medication review. The mean reduction in medications was 3.53 (±1.01). This represents 32.7% reduction in total medications. On average males were prescribed 11.8 (±4.54) medications and 4.1(±1.66) were stopped while females were prescribed 8.2(±4.97) and 2.2(±1.30) of these were stopped.

At the one-month review none of the previously stopped medications had been restarted. A total of one extra medication had been added. No inappropriate medications were recorded. Therefore, according to STOPPfrail criteria the rate of inappropriate prescribing decreased from 32.7% to 0%.

This audit into an elderly inpatient population in an approved psychiatric centre resulted in substantial reduction of almost one third of prescribed medications. The most common reason for stopping a medication was no clear indication, followed by lipid lowering therapies which give no clear short-term benefit to this population. Other common criteria used for stopping medications include stopping memantine where it is not clearly improving BPSD symptoms, proton pump inhibitors at full dose for over eight weeks and multivitamin supplements prescribed with no clear deficit.

The authors found the STOPPfrail tool to be very easy to use and appropriate for the study population. The criteria were clear, limited and there was obvious benefit to each one. Having such a peer reviewed structure for deprescribing in this population provided confidence to discontinue medications where apprehension of adverse outcome may have previously prevented the activity.

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