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Deprescribing within English care homes: guidance and recommendations from the STOPPING project

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ABSTRACT

Background: Care home residents often experience polypharmacy. Deprescribing, or the reduction or stopping of prescription medicines that may no longer be providing benefit, is generally safe but it is unknown how to make it work well in care homes.

Aim: Develop recommendations and guidance for implementing a deprescribing approach that is feasible and suitable within care homes.

Methods: The findings from two qualitative work packages of the STOPPING project were synthesised to inform guidance for deprescribing within care homes. In total, 42 interviews were conducted with 36 participants from 15 different care homes. A framework analysis approach, informed by an implementation science framework, was used to analyse and combine data from both work packages.

Results: Key considerations for deprescribing in care homes are as follows: engaging multiple individuals and organisations; recognising their various roles, responsibilities, expertise, and beliefs; information access and sharing; and active monitoring of the impact of deprescribing. The key factor is the quality of local working relationships.

Discussion: Communication and collaboration between care homes and healthcare professionals are essential to ensure deprescribing is done well. The guidance suggests several courses of action and resources for how to improve future deprescribing in care homes.

PLAIN LANGUAGE SUMMARY

People living in care homes often take many medicines. Some of these medicines may no longer help and cause harm. Deprescribing is the reducing or stopping medications that are no longer beneficial. While generally safe, deprescribing can be complicated to do in care homes because residents take several medications and may have memory problems, and families or staff may resist, making it hard to safely stop unneeded drugs. Using findings from two studies, we developed guidance for deprescribing in care homes. Good communication and collaboration between care homes, caregivers, and healthcare professionals are key for deprescribing to be done well.

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Deprescribing; medicine optimisation; long-term care; older adults; polypharmacy

Introduction

Almost 280,000 people aged 65 years and over in England and Wales live in care homes (Office for National Statistics, 2023). Older people living in care homes often have multiple long-term conditions and complex multimorbidity (Barker et al., 2021). As a result, residents are often prescribed many medicines (also known as polypharmacy), with some prescribed an excessive amount or with known harms (MacRae et al., 2021). Polypharmacy is widespread, with over 60% of care home residents taking five or more medicines (Specialist Pharmacy Service, 2022). It can cause a significant but avoidable burden and be a source of harm for older people, as it is associated with impaired cognition, falls, disability, frailty, and death (MacRae et al., 2021) and places a strain on health and care systems (Tarrant et al., 2023). This issue is recognised

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not only in England but globally, with the World Health Organization's Medication Without Harm initiative that aims to reduce harm from problematic polypharmacy (World Health Organization [WHO], 2017).

To mitigate the harms and optimise care in the UK, the National Institute for Health and Care Excellence [NICE] (2015, 2016, 2017) endorses deprescribing – the process of reducing or withdrawing inappropriate medicine, supervised by a healthcare professional. The recent Chief Medical Officer's report on health in an ageing society even stated 'improving quality of life in older age sometimes means less medicine, not more' (Whitty, 2023, p. 8). There are two types of deprescribing can happen in practice. Reactive or stopping a medicine in response to an adverse outcome is common practice across care settings (Scott, 2021), but this only occurs after patient harm and the associated costs have already happened. Whereas proactive deprescribing attempts to avoid these harms before they occur, it is an effective strategy to reduce medication-related harm (NICE, 2015, 2016, 2017). Proactive deprescribing is more difficult to undertake than reactive deprescribing as it involves an assessment of the chances of harm versus the chances of benefit (Scott et al., 2021) as well as discussions about deprescribing with older people, and potentially their family carers (Ailabouni et al., 2022). This type of describing is the focus of this article. NICE (2015, 2016, 2017) recommends deprescribing as part of the regular comprehensive review of someone's medication, especially if they are living with multiple long-term conditions. Previous research has found that deprescribing is generally safe (Reeve et al., 2018).

Deprescribing in care homes can reduce the number of potentially inappropriate medications, falling incidents, and mortality (Kua et al., 2019). Despite this evidence supporting deprescribing and national guidelines, proactive deprescribing does not always occur in care homes and little is known about how to make it work well in care home settings. Deprescribing in care homes can be particularly complicated due to factors like polypharmacy, cognitive impairments, fragmented care systems, medication burden, resistance from residents or families, and a lack of regular medication reviews, all of which make it difficult to safely reduce unnecessary medications (Quek et al., 2023; Reeve et al., 2014; Scott et al., 2015). Moreover, in England, residential care homes are reliant on primary care for access of medical care and information about medicines (Pharmacy Integration Fund, 2018). Therefore, a better understanding of how (proactive) deprescribing for older adults in care homes can be done well is needed.

The Understanding Stakeholders' Perspectives on Implementing Deprescribing in Care Homes (STOPPING) project explored the factors that influence implementing deprescribing for older adults in care homes (Warmoth, Day, et al., 2020; Warmoth et al., 2023, 2024). This report shares the main overarching findings of the STOPPING studies and provides recommendations and guidance for implementing deprescribing in care homes, to enable best practice and optimise resident care.

Methods

The content of this report builds on the research that was undertaken as part of the STOPPING project. By focusing on these qualitative studies, a more detailed, context-specific understanding of deprescribing within English care homes was attained, helping to create guidance that is relevant and actionable. This targeted approach allowed for rich, nuanced data to be gathered from those who are directly involved in care home settings, ensuring that the guidance and recommendations are grounded in real-world experiences. Two qualitative work packages were performed for the STOPPING project: 36 semi-structured interviews with residents and their family members/friends, care home staff and healthcare professionals about their experiences and beliefs about what influences deprescribing in 15 different care homes (Warmoth et al., 2023) and 8 think aloud (cognitive) interviews with care home staff assessing current deprescribing tools/approaches about their acceptability, feasibility and suitability for use in care homes (Warmoth et al., 2024). The combined demographic information and characteristics of the participants from both qualitative work packages is provided in the Supplementary File.

A framework analysis approach, informed by the Consolidated Framework for Implementation Research or CFIR (Damschroder et al., 2009), was used to analyse data from both work packages. CFIR (2009 version) is a well-established, theoretically based implementation science framework, comprised of 39 constructs divided into five domains that shape the implementation of health services (see Figure 1). The STOPPING project used this implementation science framework to interpret the findings of both studies so the approach incorporates factors that determine implementation. Full reports of the methods and findings of each piece of work have been published elsewhere (Warmoth, Day, et al., 2020; Warmoth et al., 2023, 2024). Similar and divergent determinants spanning all CFIR domains were aggregated from both studies. See Supplementary File for quotes

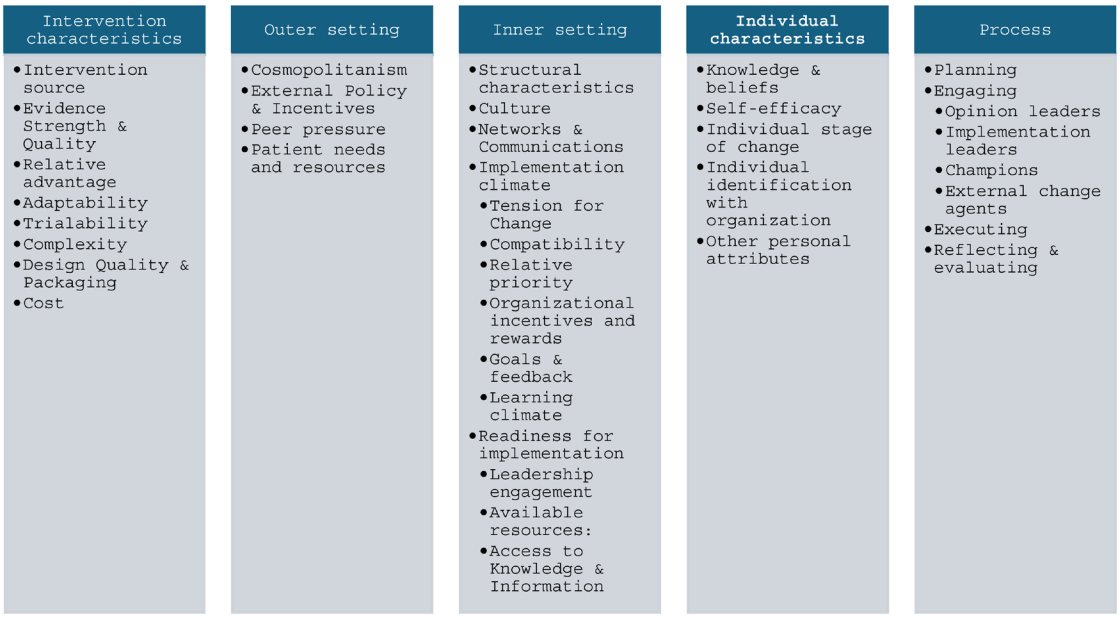

Figure 1. Consolidated Framework for implementation Research (CFIR) domains and constructs (developed based on Damschroder et al., 2009).

illustrating CFIR constructs and domains from both studies. Then how and why key factors (e.g. deprescribing as a complex process, internal and external contextual factors, and approach characteristics and its function and use) operated were considered from generating relationships using conceptual mapping technique. This technique was used to visualise the findings, organise the relationships between factors and clarify complex concepts. Two experienced qualitative researchers (who had been coders and analysed data for each work package) and a family carer representative met regularly to discuss discrepancies, refine the themes and develop the guidance. From these activities, the guidance and recommendations were developed for a deprescribing approach for care homes, which included the recommendations that are presented in the Results.

Results

Figure 2 displays a diagram of the recommendations for developing a deprescribing approach. It is presented as a cycle to represent deprescribing as a process (a key finding from Work package 1), which then works through four implementation aspects to encourage deprescribing in care homes (developed from both study findings relating to the CFIR domain of process). Proposed actions are provided for each implementation aspect and presented as questions for consideration. These actions and questions were developed from not only major themes from factors that influence deprescribing in English care home settings (Work package 1) but also feedback about existing deprescribing tools and approaches and suggestions for deprescribing approaches for care home settings (Work package 2). These recommendations are a guide rather than a rigid set of steps, as some activities overlap and feed into each other.

Plan and coordinate

It was viewed that every prescriber and care home should establish the goals of care with respect to medicine optimisation and deprescribing for residents. This would consider the relative advantage (or value) of deprescribing, and the resident's needs, preferences and capacity. Residents can be frail, have multiple long-term conditions, have cognitive impairment and be in their last years of life. Participants discussed how these factors add complexity to deprescribing and must be considered in decisions to deprescribe.

An inter-organisational and coordinated approach was suggested to be employed for planning, decision-making and reviewing medications. This includes not only prescribers (GP, consultants and pharmacists) but also care home staff, residents and family carers. Participants stated that a coordinated approach will allow all key people to participate in deprescribing conversations and planning.

Participants stressed how any approach or plan to deprescribe will need to allow for tailoring to specific needs and available resources of care home residents

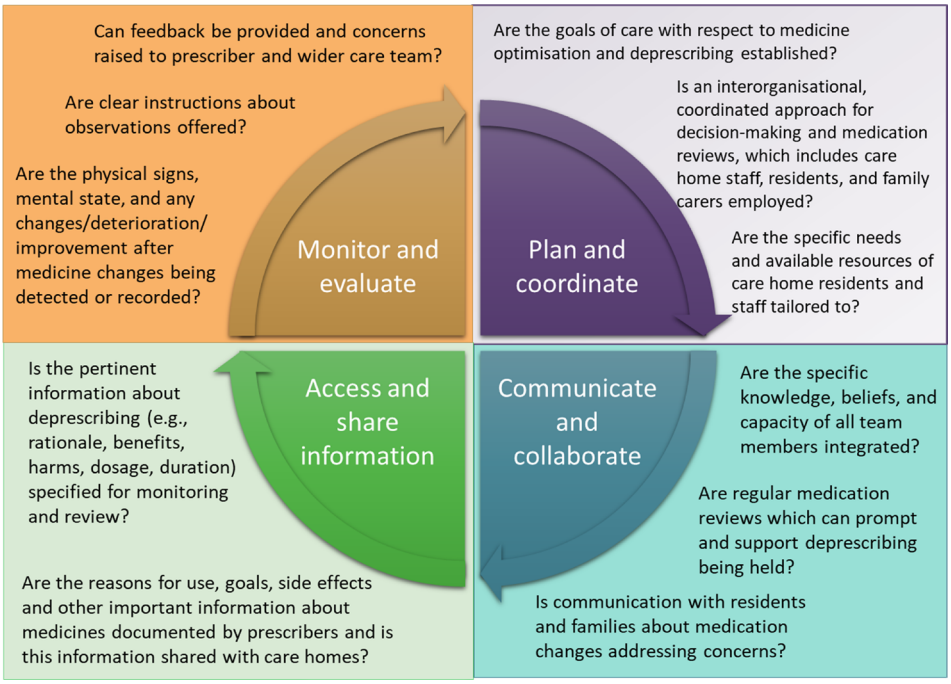

Figure 2. Diagram of the recommendations for developing an approach to deprescribing within care homes.

and staff. Different care homes will have different access to training, number of residents and practices.

Communicate and collaborate

Participants advised that implementing deprescribing in care homes be collaborative, involving multiple individuals and organisations with various professional roles and expertise, participants reported. All these individuals will have specific knowledge, beliefs, capacity and confidence that should be recognised in deprescribing conservations and execution. It was recommended that any deprescribing approach will need to consider these different individuals' knowledge and understanding of medicines. For example, care home staffs are experts in resident needs and behaviours, whereas pharmacists are experts in medication and GPs ultimately make the deprescribing decisions.

The importance of medication reviews was stressed by participants and they advised that regular medication reviews should be conducted to prompt and support deprescribing. These reviews could happen during routine discussions about medications and care, such as when new residents arrive for care planning review meetings. Participants suggested that this will make the best use of those existing opportunities for discussion and collaboration.

The role of communication was considered central in deprescribing by participants. They advise that communication with residents and families about medication changes should be done reassuringly to address any deprescribing concerns and discuss the possibility of re-starting medications if needed. There is a risk of losing the resident's voice or input in these decisions so an effort should be made to clearly explain to residents and their families why and how deprescribing is being undertaken. This point was highlighted in the interviews and recommendation for the function of a deprescribing approach.

Access and share information

Prescribers should clearly document reasons for any medication's use, goals, major side effects, and other essential information, as participants stated that this was not always what was done in practice. Participants stressed wanting access to more knowledge about prescribing and information about medicines; this information should be shared with care homes promptly and be easily accessible. Care home staff described how they are not medically trained and do not have the same access to information, systems, and resources as NHS organisations (e.g. electronic medical records). Therefore, this information needs to be shared in easily comprehensible language and arrangements should be in place regarding information storage and access, as participants discussed how this was not the current arrangement.

Participants discussed challenges of deprescribing without necessary information or support from

prescribers. Thus, prescribers must share and specify the pertinent information about deprescribing (e.g. rationale, benefits, possible harms, dosage and duration) with care homes for review before deprescribing and monitoring following any changes. More informed care home staff will be able to make relevant observations and contribute meaningfully to deprescribing conversations.

Monitor and evaluate

Participants discussed the major role of care homes in the monitoring and evaluation of any medication changes. Monitoring for side effects and/or benefits following stopping or reducing medicines forms an important part of the deprescribing process. Therefore, physical signs and/or mental state, and any changes/deterioration/improvement need to be monitored before and after any medication changes. A suggestion provided by participants was that clear instructions or checklists on what changes or symptoms to observe should be offered. Care home staffs are responsible for detecting and recording changes in residents and reporting observations so participants suggested that they should have greater access to shared reporting/follow-up systems.

Participants also discussed how there should be opportunities for providing feedback and raising concerns to prescribers and the wider care team, as this was not common practice. Team members should be empowered to question and raise concerns about residents' medicines, especially care home staff. It was recommended that these opportunities should coincide with when changes are observed, medicines are being tapered or stopped, and transitions of care (e.g. discharge from the hospital). This information was thought to be crucial if a medication needs to be restarted or any changes to the planned deprescribing are warranted.

Discussion

This report draws on the findings from two qualitative work packages from the STOPPING research project (Warmoth et al., 2023, 2024) to develop a better understanding of how proactive deprescribing for older adults in care homes can be done well. Work package 1 explored the factors that may help or hinder deprescribing practice for older people within care home, and Work package 2 assessed deprescribing tools for acceptability, feasibility and suitability for the care home setting. The findings were aggregated to develop recommendations and guidance for implementing a deprescribing approach that is feasible and suitable implementable within care homes. Several lessons were learned for improving future deprescribing in care homes and insights into making implementation a success (see Figure 2). For instance, proactive deprescribing for older adults in care homes requires constructive communication and collaboration across health and social care. It is complex, with multiple steps and the involvement of many people with distinct roles and responsibilities, and involves internal and external contextual factors, such as access to knowledge and information about medicines and the specific needs of the residents (Warmoth et al., 2023). Open communication between all stakeholders ensures a smoother, safer transition away from unnecessary medications.

The working relationships between health care (including GPs, pharmacists and other prescribers) and care homes and how these professionals communicate were important determinants of deprescribing (Warmoth et al., 2023). In other words, care home staff and healthcare providers need to work closely to ensure deprescribing is done safely and effectively. Other research has found that better collaboration and communication between providers as well as multidisciplinary team working supported proactive deprescribing and reduced the number of medications taken by residents (Birt et al., 2022; Quek et al., 2023). Care home staff identified their need for resources to facilitate communications with prescribers, especially when a resident needs a medicines review or following a medication change (Warmoth et al., 2024). There are a variety of deprescribing communication tools available yet these tools are often designed for the primary care visit, used to facilitate patients' understanding, not easily accessible, and not validated or tested (Chan et al., 2023). Therefore, research and resources need to be developed to address this unmet need and aid communication about medications in this setting.

Various distinct types of existing deprescribing tools and approaches, namely, a general deprescribing guidance, a generic (non-drug specific) deprescribing framework, a drug-specific deprescribing guideline/guide, a tool for identifying potentially inappropriate medications and an electronic clinical decision support tool, were reviewed (Work package 2) and feed into the recommendations and guidance for implementing a deprescribing approach presented in Figure 2. The tools were viewed as not helpful in the care home setting by staff (Warmoth et al., 2024), as these tools were frequently designed for the prescriber. Care home staff recommended these tools be designed with and for care home staff specifically. Consultation work

with different stakeholders, including care home staff, about medication optimisation for older people living in Canadian long-term care homes suggested actions to create an environment where deprescribing is a sustainable one (McCarthy et al., 2022). The findings of this work echo the guidance and recommendations presented here. Further work is needed to evaluate and refine these approaches as very little has been done to date; however, work offers valuable insights into the actions and considerations from the perspective of care home staff.

Deprescribing involves shared decision-making that considers what residents value and what they prioritise (Department of Health & Social Care, 2021; Sawan et al., 2022). Care home residents, family members (if possible and appropriate), care home staff and relevant healthcare professionals should be involved in the deprescribing process and their respective knowledge recognised and valued for shared decision-making (Warmoth et al., 2023). Care home staffs have recognised that this can challenging and want resources or training to support shared decision-making around medications for their residents (Warmoth et al., 2024). Resources like those developed in Canada (https://deprescribing.org/resources/deprescribing-in-ltc-framework/) to support behaviour changes to facilitate deprescribing activities for people living in long-term care homes (Farrell et al., 2019) may offer some assistance with this challenge; however, these may need further development and evaluation to be suitable for UK care home setting. Evidence shows when patients (and their family carers) engage in shared decision-making and discussion about treatments, they are better informed about potential outcomes (Stacey et al., 2024). Residents have the right to safe medication management, effective outcomes, and involvement in developing care plans (Royal Pharmaceutical Society, 2019). Shared decision-making is therefore a key component of person-centred care, achieving safe and quality use of medications.

Strength of the work is the use of a comprehensive, well-recognised implementation science framework to inform the research and to aggregate the findings of two qualitative studies. By focusing on these qualitative studies, a clearer, context-specific understanding of deprescribing in English care homes was gained, resulting in practical and relevant guidance. This approach captured valuable insights from those directly involved in care, ensuring that the recommendations are rooted in real-world experience. However, this approach also has limitations. Most of the STOPPING participants were care home staff so the findings reflect their perspectives and experiences. Another limitation is that the guidance was developed from research undertaken in a single region of England, which limits the generalisability of the model to other countries and regions with the country. Further research should be conducted to confirm the transferability of the findings to other regions and countries. More work is needed to develop tools and approaches that address how this guidance can be achieved within current structures and limited resources of health and social care.

Conclusion

Communication about deprescribing and shared decision-making about medications should involve people sharing their experiences and goals for medications, who then share their knowledge of medication effectiveness and side effects to determine the best approach (together) for an individual care home resident (Jansen et al., 2016). The guidance presented in this report gives several courses of action for how to improve future deprescribing in care homes. While further work is required, we have made initial progress toward a better understanding of how to effectively implement deprescribing for older adults in care homes.

Authors' contributions

KW contributed to conceptualization, methodology, analysis, investigation, writing – original draft, project administration, and funding acquisition. JD contributed to funding acquisition, writing – reviewing and editing. AA contributed to writing – reviewing and editing.

Ethical considerations

Ethical approval to conduct the STOPPING study was given by the Social Care Research Ethics Committee (19/IEC08/0058).

Disclosure statement

No potential conflict of interest was reported by the authors.

Declaration of interest statement

The authors report there are no competing interests to declare.

Data availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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