

# Saving the Elderly From Drug-Related Harm

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**Christopher P. Alderman, BPharm, PhD, FSHP, BCPP, CGP**  
**Ward Medication Management, Abbotsford, Melbourne, Australia**

It goes without saying that older people are known to be at definitive risk of iatrogenic harm, with the relative extent of the hazard involved influenced by many factors. It has been pointed out that the first step in preventing this harm is the identification of those who are most at risk.<sup>1</sup> A person's domiciliary circumstances, support systems, specific comorbidities, the presence of cognitive impairment, the quality of medical and pharmaceutical care, the number of medications taken, and the specific types and combinations of these are all known to influence the likelihood of drug-related harm affecting elderly people. Much of what has been written about iatrogenic harm affecting older people has focused on the hospital setting, and with good reason: in this setting, the drugs that are used are powerful, the patients are inherently very sick, and factors such as significant renal impairment and serious infections are common. In addition to this, care processes are complex, creating potential for medication errors, especially at interfaces of care settings (eg, admission to and discharge from hospital). However, if attention were to be focused exclusively on the hospital setting, it is plain that a substantial proportion of the extent of medication-related harm would remain unscrutinized. Reflecting the fact that the majority of medication use actually takes place in the community, it is now known that a large burden of medication-related harm originates in this setting.<sup>2</sup> In addition, the residents of aged facilities are also at grave risk, thought to originate from a range of factors such as difficulty accessing medical staff, complex and busy workload for nursing staff, suboptimal training, inaccurate records and others.<sup>3</sup>

All things considered, although ongoing research to quantify and analyze medication-related harm is welcome, many would argue that now is the time to focus on the design and assessment of strategies that make an impact on reducing the prevalence and impact of this scourge on the elderly. Over the years, clinicians working in geriatrics have seen the development and promulgation of tools such as the famous Beers Criteria and the STOPP criteria, with the objective being to assist pharmacists and physicians in identifying drugs that might merit consideration as candidates for discontinuation from the medication regimens of older people. The *deprescribing* phenomenon has been

widely embraced as a structured process to attempt reduction of exposure of older people to extensive medication. In this edition of *The Annals*, we see analysis of another aspect of the processes required to work toward better prescribing and less hazardous medication use for older people, where researchers have explored attitudes and beliefs of those involved in the multidisciplinary interactions between medical prescribers and pharmacists.<sup>4</sup>

Given that the harm associated with polypharmacy among elderly people is substantial and the issues involved are well understood, the question remains as to how to facilitate more effective cooperation between the key players that can drive improved prescribing and a decrease in drug-related morbidity. In the United States, Great Britain, and Australia, programs have been set up that allow pharmacists to work with primary care physicians in undertaking medication regimen review—these processes are known by various different names such as Medication Therapy Management, Clinical Medication Review, and Home Medicines Review. Even though these opportunities exist, the research by Kouladjian et al<sup>4</sup> suggests that the output of these reviews is not necessarily translating into constructive changes in the medication profiles of the patients. One possibility that cannot be ignored is that perhaps pharmacists who prepare the reports associated with the medication reviews may be technically skilled at detecting drug-related problems but may not necessarily convey this information to prescribers in a way that effectively translates into changes in medication orders. The frustration that pharmacists express in relation to physicians not implementing their recommendations may in fact be related to the ways in which they interact with physicians, both verbally and in written reports.

The factors that motivate changes in prescriber behavior are extremely complex, and there are many theories that underpin the foundations of effective interprofessional communication. Research conducted to date suggests that the simple act of providing information is probably not enough to translate into safer prescribing for older people. Over decades, pharmacy educators have embraced the challenge of providing training for students that confers excellent technical competency with respect to clinical drug

information, providing the foundation for a paradigm shift in the profession away from practice primarily based in product formulation and dispensing and, instead, concentrating on accountable pharmaceutical care. This change in educational focus is welcome, but it is apparent that the profession has only traveled part of the way toward engineering a workforce that can deliver care for older people in cooperation with other key professions. These so-called soft skills can be acquired but require concentrated effort in development. In the case of medication regimen review, a pharmacist must not only be able to detect and tactfully document the medication-related problems that are present or that have the potential to develop, but also to offer clear solutions with an evidence base and convey these in a format that will be likely to be translated into action by the doctor receiving them. The skills required to accomplish these tasks are built in experiential training, are fostered by mentorship, and require leadership from within the pharmacy profession to ensure a future for the profession. One excellent mechanism by which leading edge practitioners with these sophisticated skills and experience can be identified is through the process of specialty practice certification—in the case of pharmacists providing medication review for older people, practitioners can seek recognition as certified geriatric pharmacists (CGPs) under the international umbrella structure provided by the Commission for Certification in Geriatric Pharmacy. Many CGPs in North America and Australia are currently practicing in situations where they provide medication reviews for older people in community-based settings and aged care facilities. The CGP certification process involves a competency-based assessment system that not only focuses on a candidate's knowledge of drugs and disease states, but also incorporates elements relating to soft skills required for geriatric pharmacy practice.<sup>5</sup>

As much as pharmacists performing medication reviews for the elderly need excellent written and verbal communication skills, it is also important to acknowledge that all communication is a two-way street. When presented with clear, well-reasoned, evidence-based recommendations for

modifications for drug therapy regimens and overall patient management, it is incumbent on the medical staff involved to act on these. Devolving responsibility to undertake this task does not achieve the desired result of reducing exposure to potentially harmful treatment. Although the research referred to earlier in this discussion<sup>4</sup> suggests that general practitioners (primary care physicians) might view the task of guided deprescribing as one owned by specialist physicians, the reality is that specialists often only manage part of the portfolio of work required to care for elderly people in the community, whereas the general practitioner has a more global view of all the issues and often enjoys a long-standing therapeutic relationship with the older person. Embracing accountability for putting into effect high-quality recommendations made by competent professionals can only improve the quality of care provided and reduce the likelihood of iatrogenic harm. The statistics cannot be misread; there are still far too many older people hurt or killed by the direct or indirect effects of their medications. This situation will not change until all the relevant people involved are engaged and act, and the sooner this happens, the better.

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