NDIS Quality and Safeguards Commission

Practice Alert

Polypharmacy

November 2020

Key points

- Polypharmacy is often defined as the use of five or more medications, or two or more psychotropic medications, at the same time.
- Polypharmacy increases the risk of medication-related adverse effects and poorer health outcomes.
- Participants taking multiple medications should have these reviewed every 3 to 6 months by a medical practitioner or pharmacist.

What is polypharmacy?

Polypharmacy is the concurrent use of multiple medications (often defined as five or more medications) to treat one condition or multiple concurrent conditions. It includes the use of all prescription medicines, over-the-counter medicines, and complementary medicines.

Polypharmacy use is significantly higher in people with disability. This is partly because people with a disability are more likely to have multiple health conditions, such as epilepsy, diabetes, stroke, heart problems, high blood pressure, and arthritis compared to the general population.

Psychotropic polypharmacy refers to concurrent use of two or more medications that can affect the brain's function. Psychotropic medications are 'any drug capable of affecting the mind, emotions, and behaviour.' The three main classes of psychotropic medicines are antidepressants, anti-anxiety agents (mostly benzodiazepines to manage anxiety and insomnia) and antipsychotics. Psychotropic polypharmacy is common in people with autism or an intellectual or developmental disability. Although people with these disabilities are more likely to receive medications because of co-existing mental health problems, medications are often prescribed without a diagnosis of a psychiatric disorder. Antipsychotics are also frequently prescribed to manage behaviours of concern, such as self-injury or aggression.

When is polypharmacy more likely?

High rates of polypharmacy are associated with participants who:

- live in a residential setting
- receive prescriptions from multiple prescribers
- have moderate to severe intellectual or developmental disability
- have a poorer overall health status
- have co-occurring psychiatric, neurological or developmental disorders
- have multiple neurological or psychiatric diagnoses

What are the risks associated with polypharmacy?

Large-scale studies have shown that polypharmacy increases the risk of drug-related adverse effects. It is a leading reason for medication-related hospitalisations, can decrease the benefit of individual medications, and is associated with poor health outcomes.

The use of multiple antipsychotics can increase the risk of:

- movement disorders
- hormone disorders
- sexual dysfunction
- obesity
- diabetes
- stroke and heart attack
- memory issues
- falls
- sedation.

The World Health Organisation and Australian Commission on Safety and Quality in Health Care have identified reducing the risks associated with polypharmacy as a major priority.

Importance of polypharmacy review

Despite the risks associated with polypharmacy, it may be the most appropriate treatment, particularly for people with multiple conditions.

To ensure participants are receiving the correct medications, a review of all medications by a medical practitioner and pharmacist allows each drug to be assessed in terms of need, current and recommended dosages, benefit versus risk of potential adverse effects or other side effects, and possible interactions between medications.

Regular medication reviews can prevent or minimise polypharmacy-related adverse effects and related hospitalisations, by helping participants, support workers, carers and caregivers to better understand how to use the medications correctly, and how to manage potential adverse effects.

People with disability are among those most at risk of polypharmacy due to comorbid health conditions and the common use of several medicines of the same class (e.g. antipsychotics). A

medical practitioner should conduct a medication review every 3–6 months, or when requested by the participant, their carer or other health or disability professionals.

Home Medicines Reviews

A Home Medicines Review (HMR) is a collaborative medication review for people in the community. A referral from a GP or medical specialist is required. An accredited pharmacist interviews the patient and reviews their medications, then provides a report to the participant's doctor. It aims to maximise the patient's benefit from their medication regimen, and prevent medication-related problems. It is fully subsidised by Medicare for eligible patients and is available every 24 months to any person at risk of, or experiencing medication related adverse effects.

If clinically necessary, a HMR can occur more frequently than 24 months in the following scenarios:

- significant change to a patient's medication regimen in the past three months
- change in medical condition or abilities (including falls, cognition, physical function)
- prescription of a medicine that may be more likely to cause harms
- symptoms that suggest an adverse drug reaction
- inadequate response to medications
- suspected non-compliance or problems with managing medications.

Recommended ways to support NDIS participants receiving polypharmacy

- If participants are receiving multiple medications, arrange for a medical practitioner or pharmacist to review these every 3 to 6 months. This is because a participant may experience adverse effects when they take multiple medications.
- In addition, if participants take five or more medications (or two or more antipsychotics), arrange to have their medications reviewed by a pharmacist through the HMR program.
- Keep a record of when participants last had their medications reviewed.
- Ensure that participants, carers and/or support staff have ready access to a full list of the participant's current medicines. Tools such as the NPS MedicineWise App or electronic medication records such as My Health Record can assist with this.
- Make an appointment with a medical practitioner if you suspect that a participant may be experiencing adverse effects due to medications, particularly if there has been a recent change in medication.

Provider obligations related to polypharmacy

NDIS Code of Conduct

The NDIS Code of Conduct requires all NDIS providers and workers who deliver NDIS supports to NDIS participants to, among other things:

- provide supports and services in a safe and competent manner with care and skill
- promptly take steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

NDIS Practice Standards

As a registered NDIS provider, you also have obligations under the NDIS Practice Standards and Quality Indicators, as part of your conditions of registration, that relate to the delivery of safe, quality supports and services, and the management of risks associated with the supports you provide to NDIS participants.

The NDIS Practice Standard and Quality Indicator that is most relevant to this alert relates to **Medication Management.** This standard applies to a provider that is responsible for administering medication to participants. The standard expects that each participant requiring medication is confident their provider administers, stores and monitors the effects of their medication and works to prevent errors or incidents.

To achieve this outcome, the Quality Indicators state the following should be demonstrated:

- Records clearly identify the medication and dosage required by each participant, including all information required to correctly identify the participant and to safely administer the medication.
- All workers responsible for administering medication understand the effects and side-effects of the medication and the steps to take in the event of an incident involving medication.
- All medications are stored safely and securely, can be easily identified and differentiated, and are only accessed by appropriately trained workers.

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