Shared Decision-Making in Medication Management Process Guide for LTC

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Shared Decision-Making in Medication Management

Process Guide for People Living in Long Term Care, their Families, Essential Care Partners and Healthcare Providers

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Created by the Ontario Deprescribing in LTC Stakeholder Team

The purpose of this guide and how to use it

This guide is intended to help people living in Long Term Care (LTC) homes, their families, essential care partners, and healthcare providers work together to manage medications according to personal goals. People should aspire to follow these processes together. When provided at the time of admission, this guide will improve the participation of residents and their families in important medication decisions. It can also be used to inform policies and daily practice aligned with resident-centred care. It has been produced by a group of Ontario LTC home stakeholders interested in improving medication management, particularly to support decisions about when and how to continue or reduce medications safely. Resources and partner documents for residents/families, essential care partners, healthcare providers and LTC home team members are included to help people use the guide. The guide has been produced with a focus on ideal practice to support shared decision-making in medication management. Changes may need to be made to both LTC home practice and payment models to incorporate these activities and discussions; such changes are of the utmost importance to ensure quality medication use and outcomes.

The process is consistent with the Ontario LTC Homes Act

Shared decision-making for medication management is consistent with many aspects of the LTC Homes Act. These include the goals of safe medication management and effective drug therapy outcomes, the right for people living in LTC homes (or their Power of Attorney (POA) or Substitute Decision Maker (SDM)) to take part in decisions affecting their care, to participate fully in the development of their care plan and to have their choices and decisions respected. This includes when their decision is different from the recommendations of healthcare providers. It is consistent with the care plan required for each person and includes goals that reflect their needs and preferences, one that is explained to them when needed, reassessed with them on a regular basis and shared amongst team members and healthcare providers to ensure consistency and complementary care.

Shared decision-making in medication management

The goal of 'shared decision making' by people living in LTC, their families and healthcare providers is to improve decisions about care – including medication use. Shared decision-making involves people sharing their experience and goals for medications with healthcare providers, who in turn share their

knowledge of medication effectiveness and side effects to determine the best approach (together) for an individual person.

This helps to develop good care plans and improve quality of life for people living in LTC homes

Decisions about medications can involve continuing with the same medication, starting a new medication, changing a dose or stopping a medication. Sometimes, one of these approaches may work better and be safer. For example, changing, reducing, or stopping a medication can often improve care and quality of life by reducing side effects and drug interactions. When making decisions about medication related care, everyone needs to think about whether a different medication might be more helpful, or whether, for example, lowering the dose or stopping a medication might reduce sedation and improve function (making it easier to eat or use the toilet), reduce pill burden and increase staff time to care for people in other ways.

These are all important things to consider and discuss in making decisions about medication use.

Roles and responsibilities in shared decision-making

These types of decisions are a responsibility shared by the person living in LTC (or their substitute decision maker) and healthcare providers. Family members, essential care partners, or Powers of Attorney for Personal Care or Substitute Decision Makers are involved as needed. Healthcare providers may include doctors, nurses, pharmacists and other team members within the LTC residence. Other team members, such as personal support workers, recreational therapists and dietitians, are involved by sharing their observations on a person's experience with a medication (such as changes in behaviour, changes in reliance on team members).

To take part in shared decision-making, healthcare providers bring knowledge about the medication's usefulness and side effects to the person living in LTC and their family. Residents and their family members bring information about medication experiences and observations, goals and values, and priorities for quality of life to share with healthcare providers. These perspectives are shared during a discussion with a goal to reaching a decision about a medication that everyone agrees with. Providers must make all efforts to include and hear the experiences and preferences of people living with dementia and not simply default to family members. This includes the use of accessibility and understandability aids.

These discussions show the partnership of residents and their families with healthcare providers to ensure the person living in LTC has the best possible quality of life. This is an important aspect of resident-centred care.

When does shared decision-making about medications happen?

Shared decision-making discussions about medications should happen at the time of admission, at regular medication reviews (i.e., team discussions about the ongoing usefulness of each medication that are required by the LTC Act every 3 months), when people are re-admitted after being in hospital, and at all care conferences. They should also be encouraged anytime a resident has a change in their condition. Anyone who notices such a change in condition (e.g. staff member, healthcare provider, resident, family) can and should ask for a medication review.

Steps in shared decision-making

There are important steps to holding good shared decision-making conversations. By using these steps routinely, the time needed to hold these discussions will be rewarded with improved well-being, less medication harm and better relationships.

From the resident/family perspective, the general steps of shared decision-making include:

1. Recognize that a decision about a medication may need to be made (this could happen if someone notices a change in condition or goals of care). Decisions might include starting a medication, changing the dose, changing to a different medication, stopping a medication or using a non-drug strategy.
2. Ask about the benefits, risks and expected outcomes of each option and listen to what the healthcare provider says about reasonable expectations.
3. Feel informed about each option and ask questions if not sure.
4. Feel clear about goals of care and your/resident's preferences
5. Discuss goals of care and your/resident's preferences with healthcare providers.

6. Help to make an informed decision about the medication options; let the healthcare provider know if you change your mind.

From the healthcare provider perspective, the general steps of shared decision-making with the resident/family include:

1. Notify the resident/family about medication discussions that are scheduled or need to happen and invite participation.
2. Invite the sharing of observations and preferences that should be considered in the identification of medication effectiveness or problems
3. Define the potential medication problem and present options (e.g. starting a medication, changing the dose, changing to a different medication, stopping a medication or using a non-drug strategy); discuss pros and cons (share knowledge about the option's benefits, risks and expected outcomes); describes strategies that would be used to make changes (e.g. monitoring)
4. Ask about resident's goals and preferences for the different options.
5. Verify resident/family's understanding of the options and potential outcomes.
6. Assess uncertainty and clarify where needed.
7. Respect differences of opinion and accept decisions made by the resident (or their POA or SDM as appropriate). (Agreeing on a care plan that reflects best clinical practice and the resident's goals and preferences)

Process for using shared decision-making at the time of admission

The medication management process in LTC homes ideally begins before or immediately on admission. The LTC pharmacist, pharmacy technician and/or registered nurse (or nurse practitioner) are involved in a process that includes compiling a Best Possible Medication History (e.g. by contacting the current community pharmacy, using the Ontario database) and talking with the resident or family to gather a complete history of medication experience. Common questions include:

- What questions do you have about your medications? Do you think you're on the right amount of medication? Too many? Not enough? (helpful to set the tone)
- Original reason for medication or not sure?
- How well did the medication work, and how well is it working now?
- What is the expectation for what the medication should be doing?
- Any side effects of the medication?
- Is the medication taken regularly or only when needed (and if the latter, how often)?
- Clarify dosing and timing
- For how long was the medication intended?
- How does the resident/family feel about continuing or reducing the medication?

The LTC pharmacist, or registered nurse (or nurse practitioner) compiles a report for the new LTC prescriber including identifying which medications may no longer be needed (e.g. not working, not matched to a current medical problem, not using regularly, no longer providing benefit) or might be

causing side effects (e.g. contributing to falls risk, cognitive impairment or other symptoms), identifying additional medications which may be more effective and allow the stopping of other medications, and identifying the resident/family's perspective about expectations from each medication. This information can be provided in a written report, or verbally if possible. Prescription changes should include the reasons for changes so the healthcare team members are all aware. The timing of this report varies across LTC homes but should ideally be provided as soon after admission as possible.

The resident and family have a responsibility to help this process by:

- Providing a list of current and past medications (including the above information which the pharmacist and prescribers need to know to understand how each medication is being used)
- Describing worrisome symptoms that might be medication-related
- Asking questions about reasons and goals for medications, including reasonable expectations about how well each medication might work

The LTC pharmacist or registered nurse (or nurse practitioner) repeats this process, as soon as possible, with the hospital staff and resident/family during a readmission following hospital care.

Process for using shared decision-making for regular medication reviews and care conferences

Regular medication reviews begin with the pharmacist assessing current medication use and how well it's working, often along with the nurse and personal support worker. To help with shared decision-making, the assessment includes a discussion with the resident and/or family about the same issues described above. A template that residents/families can complete beforehand helps make this process better. Ideally, the next step includes a group discussion with the pharmacist, nurse, prescriber and the resident/family to review the medication plan, potential changes and follow-up plans. This process currently happens but sometimes in writing only, without the group meeting in-person and with family sometimes informed after changes are made. To ensure shared decision-making occurs, teams should take advantage of virtual meetings for medication reviews and care conferences, reducing the need for people to travel to a physical meeting (making it easier to take part) and makes good use of everyone's time.

In-person or virtual annual care conferences are ideal venues for healthcare providers and residents/families to discuss medication-related goals of care and to make shared decisions. The same process for a medication review should be followed, but taken in the context of overall care planning, decisions about whether the goals of each medication are a match for the overall goals of care can be made more clearly.

Important information to know to enable shared decision-making about medications

In order for shared decision-making to happen, healthcare providers, front-line team members, residents and their families need to work together to share important information. This information needs to be shared at admission and then throughout the resident's stay.

Important information about medications should include:

- Medical history (e.g. past and present medical conditions)
- Medication history (e.g. names of medications, reasons, when started and by whom, dose changes, effect of taking medications, side effects, allergies, past medications (or medications tried in the past).
    - *Initially healthcare providers may ask questions such as: How did we get to this point with this medication? When and why was it started? How well have they done on it? Has your condition improved or become worse while taking it? Does the medication seem to be working?*
- Goals of medications
- Goals of care (e.g. symptom control, prolong life). Throughout a person's stay in the LTC home, healthcare providers need to know if and how the goals of care may be changing.
- Values (e.g. priorities; philosophy about life including fatalism, not being a burden, avoiding suffering; sociocultural values and personal background such as religion)
- Approaches to taking medications (e.g. not taking medication as prescribed, forgetting, hoarding, taking medications spaced out, needing for medications to be crushed)
- Concerns/observations about medications (e.g. confusion, disorientation, hallucinations, confabulations, twitching, jerking, sleepiness, diarrhea, constipation)
- Any changes in demeanor or behavior that might highlight that a resident needs a review of medications.

Healthcare providers also need to let residents, families and front-line team members know:

- What symptoms to monitor to see if a medication is working or causing a problem
- When to communicate about these symptoms, and
- Who to talk to about concerns