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## Shared Decision-Making in Medication Management A Guide for Long-Term Care



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## Shared Decision-Making in Medication Management

### A Guide for People Living in Long-Term Care, Families, Caregivers and Healthcare Providers

July 20, 2021

Created by the [Ontario Deprescribing in LTC Stakeholder Team](#)

#### **What can this guide do for you and who should use it?**

This guide can help people living in long-term care (LTC) homes, their families, caregivers, and healthcare providers work together to make choices about medications in a way that lines up with a resident's personal goals.

Throughout this guide, we refer to people living in LTC as 'residents'. Others involved in decision making about medication might include family members, caregivers, and the resident's Power of Attorney for Personal Care (POA) or Substitute Decision Maker (SDM). When we use the term 'residents', we always consider that one or more of these people might be involved.

The guide also can help guide policies and how people working in LTC carry out their jobs in a way that puts the needs and desires of the resident first. This is called resident-centred care.

#### **How to use this guide**

Long-term care homes should share this guide with residents and families when people first move into an LTC home or at any other time they may need to make choices about medication. Posters and other tools are also available here (<https://deprescribing.org/deprescribing-in-ltc-framework/>). We encourage care teams, residents and families to follow this guide together.

#### **Who made this guide**

This guide was created by a team from the Bruyère Research Institute and the Ontario Centres for Learning, Research and Innovation in LTC at Bruyère. This team worked with a group of Ontario LTC home stakeholders such as family councils, healthcare providers and LTC associations to get input from everyone involved in medication decisions. Everyone who helped make this guide wants to help people make better decisions about when and how to continue or stop using medications safely. The guide explains how residents and families can be part of the decisions made about a resident's medications.

#### **The process is consistent with the Ontario LTC Homes Act**

The Ontario LTC Homes Act is a piece of legislation made by the Government that all Ontario LTC homes must follow. The Act makes sure residents get safe and high-quality care every day in a way that puts them first.

Shared decision-making about medications is in line with many parts of the LTC Homes Act. These include:

- Safe medication management and effective drug therapy outcomes
- The right for residents to take part in decisions affecting their care
- The right for residents to participate fully in the development of their care plan
- The right for residents to have their choices and decisions respected - including when their decision is different from the recommendations of healthcare providers
- The requirement that each resident has a care plan that includes goals that reflect their needs and preferences, is shared within the care team and is reassessed on a regular basis

### **Shared decision-making for medications**

The goal of shared decision-making is to improve care decisions – including for medications. It includes residents sharing their experience and goals for medications with healthcare providers. Healthcare providers share their knowledge of medication effectiveness and side effects. Then, they decide as a team what the best medication plan is for that resident.

This process helps to create good care plans and improve the quality of life for residents.

Decisions about medications can include:

- continuing with the same medication
- starting a new medication
- changing the amount of medication taken
- stopping a medication

Sometimes one of these approaches may work better and be safer for an individual resident. Lowering the dose of a medication, stopping it, or changing to a different one can often make quality of life better by reducing side effects and drug interactions. For example, making a change could reduce sedation and improve function (making it easier to eat or use the toilet). Reducing the number of medications can also allow staff time to care for residents in other ways.

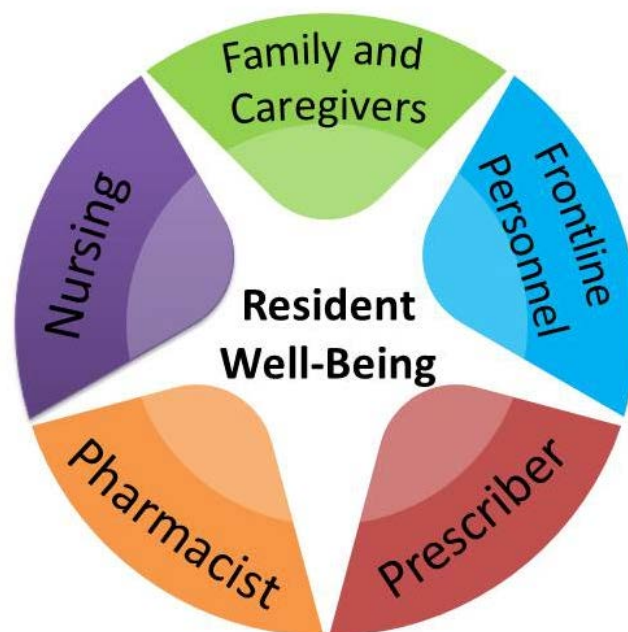
These are all important things to consider and discuss in making decisions about medication use.

### **Roles and responsibilities in shared decision-making**

Decisions about medications or treatments are a responsibility shared by the resident and healthcare providers. Family members, caregivers, or Power of Attorney for Personal Care or Substitute Decision Maker are involved as needed. Healthcare providers may include doctors, nurses, pharmacists and other team members in the LTC home. Team members, such as personal support workers, recreational therapists and dietitians, are involved by sharing their observations on a resident's experience with a medication (such as changes in behaviour, changes in reliance on team members).

Healthcare providers bring knowledge about the medication's usefulness and side effects to the resident. Residents bring information about medication experiences and observations, goals and values, and priorities for quality of life. Examples of goals of care could include focusing on managing bothersome symptoms or doing things that may help to prolong life. Values may be influenced by someone's priorities, philosophy about life and suffering, cultural background or religion. These perspectives are discussed to make a medication decision that everyone agrees with. Throughout a resident's stay in the LTC home, goals of care or values may change and it is important that the care team know this. Providers must include and hear the experiences and preferences of LTC residents living with dementia and not simply default to family members. This means that healthcare providers use tools to help the information be accessible to, and understood by everyone.

These discussions show the partnership of residents with healthcare providers to make sure residents have the best possible quality of life. This is an important part of resident-centred care.



### **When does shared decision-making about medications happen?**

Shared decision-making discussions about medications should happen at these times:

- at admission (when the resident moves in)
- at regular medication reviews (i.e., discussions about the ongoing usefulness of each medication - required by the LTC Act every 3 months)
- when residents come back to LTC after being in hospital
- at all care conferences



Medication discussions may need to happen when there is a change in the resident's condition. Anyone who notices such a change (e.g., team member, healthcare provider, resident, or family) can and should ask for a medication assessment.

### **Steps in shared decision-making**

There are important steps to having good conversations about medications. By using these steps, LTC homes will see improved resident well-being, less medication harm and better relationships.

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

1. Consider that a decision about your medication may need to be made. Decisions might include starting a medication, changing the dose, changing to a different medication, stopping a medication or a strategy that doesn't use medications
2. Share goals of care and preferences with healthcare providers
3. Ask about the benefits, risks and expected outcomes of each option and listen to what the healthcare providers says about reasonable expectations
4. Feel like you understand each option, ask questions if not sure
5. Help make an informed decision about medication options and let your healthcare provider know if you change your mind

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

1. Let the resident know about medication discussions that are scheduled or need to happen and invite participation
2. Invite residents to share their observations and preferences to help you consider medication effectiveness or problems
3. Define the potential medication problem and give options (e.g., starting a medication, changing the dose, changing to a different medication, stopping a medication or using a non-drug strategy)
4. Talk about pros and cons (share knowledge about the benefits, risks and expected outcomes); describe strategies that would be used to make changes, such as monitoring
5. Check that the resident understands the options and potential outcomes; clarify if needed
6. Ask about resident's goals and preferences for the different options
7. Respect differences of opinion and decisions made by the resident
8. Agree on a care plan that reflects resident's goals and preferences and considers best clinical practice

Once a decision has been made, healthcare providers need to let residents and staff know what symptoms to look for to see if a medication is working or causing a problem, when to speak up about these symptoms and who to talk to about concerns.

## How to use shared decision-making at the time of move-in

Shared decision-making about medications ideally begins before or right away when a resident moves into a LTC home. The LTC pharmacist, pharmacy technician, registered nurse or nurse practitioner puts together a complete history of medication use by contacting the current community pharmacy, using the Ontario database, and talking with the resident. Common questions they may ask a resident include:

- General questions like:
  - What questions do you have about your medications?
  - How do you feel about your medications?
  - What is your approach to taking medications? (e.g. need to take them spaced out, crushed, what happens if you forget)
  - What concerns or observations do you have about medications? (e.g. confusion, disorientation, hallucinations, twitching, jerkiness, sleepiness, diarrhea, constipation)
- Specific questions about each medication like:
  - What was the original reason or goal for this medication, or not sure?
  - How did we get to this point with this medication?
  - Tell me about what you think this medication should be doing for you
  - How well has the medication worked? How well is it working now?
  - Has your condition improved or become worse while taking this medication?
  - Are there any side effects of the medication?
  - Is the medication taken regularly or only when needed? How often do you take the medication?
  - How long was the medication supposed to be used?
  - How do you feel about continuing or reducing the medication?

The LTC pharmacist, registered nurse or nurse practitioner gives a report to the new LTC prescriber. The report can:

- Suggest which medications may no longer be needed (e.g., because they are not working, not matched to a current medical problem, not using regularly, or no longer providing benefit)
- Point out which medications might be causing side effects (e.g., making a resident more likely to fall, making memory or other symptoms worse)
- Recommend dose changes to reduce side effects or help a medication work better
- Recommend medications that may work better and allow stopping of other medications
- Share the resident's perspective about expectations from each medication

This report can be written or shared in person or over the phone. The timing of this report varies across LTC homes but should ideally be given as soon as possible after the resident moves in. Prescriptions should include the reasons for changes so the healthcare team members are all aware.

The resident has a responsibility to help this process by:

- Providing a list of current and past medications using a medication record like the one that can be found here: <https://deprescribing.org/deprescribing-in-ltc-framework/Medication-Record/>. This should include reasons for each medication, when it was started by whom and why, any dose changes that have happened, what the effect of the medication has been, any side effects, medication allergies, and a list of past medications and why they were stopped
- Answering the questions from the admissions team to help the pharmacist and prescribers understand how each medication is being used
- Describing worrisome symptoms that might be medication-related
- Asking questions about reasons and goals for medications

### **How to use shared decision-making for regular medication reviews and care conferences**

Regular medication reviews take place in Ontario LTC homes every 3 months. They begin with taking a look at which medications the resident is using and how well it's working. This review is done by the pharmacist often with the nurse and personal support worker. To help with shared decision-making, the team talks with the resident about the same things discussed at the time of admission. A medication record that residents can fill out before the review can help make the discussions easier.

Ideally, the next step is a group discussion with the pharmacist, nurse, prescriber and the resident to go over 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 residents sometimes informed after changes are made. To make sure shared decision-making happens, teams should take advantage of virtual meetings for medication reviews and care conferences. People don't need to travel to be part of a virtual meeting so it is easier to take part and makes good use of everyone's time.

Annual care conferences allow for healthcare providers and residents to talk about medication goals and to make shared decisions. These meetings can happen in person or virtually. Annual care conferences follow the same steps as regular medication reviews and are a good time to talk about the overall goals of care to see if the medications the resident takes still fit these goals.

### **Are there other times shared decision-making about medications might happen?**

The LTC pharmacist, registered nurse or nurse practitioner updates the medication list with the hospital staff and resident as soon as possible after a resident returns from a hospital visit. This might involve updating the goals of care and medication plans if something has changed during hospital admission.

A resident or their caregivers may also ask for a medication assessment if there has been any change in symptoms, demeanor or behavior. It is possible that such changes could be related to medications and this should always be assessed.

### **Tools that can help support you in shared decision-making about medications**

The following tools can help support residents in taking part in shared decision-making about medications:



Infographic: The infographic is a one-page visual summary encouraging residents to take part in shared decision-making conversations about their medications. It can be given directly to the resident or posted in the LTC home.

Cue card: The cue card is meant as a quick reference for residents to use when participating in shared decision-making conversations about their medications. It lists the steps involved in shared decision-making and includes examples of prompts or questions they can use.

'My Medication Record': This medication record is meant for residents to fill in with as much information as possible. It includes spots to fill in details about current and past medications, allergies, side effects, taking medications and vaccinations. Residents should share this record with their healthcare team.

Proposed statement for move-in and care conference checklists: This statement is meant for LTC homes to add to their checklists that they provide to residents at the time of move-in and care conferences. It provides residents with information about what to expect and how they can prepare for upcoming conversations about their medications. The statement can be modified by individual care homes as needed.

Videos: A number of videos have been created that show examples of good shared decision-making conversations about medications between residents and/or their families and the healthcare provider.

All of these tools are available for download at: <https://deprescribing.org/deprescribing-in-ltc-framework/>

## **Appendix 1: Acknowledgements**

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