Transforming Prescribing Safety in Psychiatry of Older Adults through Multidisciplinary Collaboration

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NHS Education for Scotland

NES ANNUAL CONFERENCE 2026: COLLABORATE. INNOVATE. TRANSFORM.

1 THE CHALLENGE OF POLYPHARMACY

Polypharmacy in older adults remains a significant challenge for health and social care services in Scotland, particularly within the Psychiatry of Older Adults (POA) setting. Patients in these wards often present with complex psychiatric symptoms alongside multiple physical comorbidities.

- This complexity frequently leads to high **anticholinergic burden** - a risk factor for cognitive decline, falls, and increased mortality (O'Mahony et al., 2023).
- Inappropriate prescribing often originates in the community or during acute transitions of care. If left unaddressed during a hospital stay, these potentially inappropriate medications contribute to a **"revolving door"** of hospital admissions due to preventable adverse drug reactions.

Goal: Transition the ward culture from *passive prescribing* to *active, multidisciplinary clinical rationalisation* using the STOPP/START framework.

2 A MULTI-PHASED AUDIT CYCLE

A 6-month closed-loop audit cycle (July 2025 - January 2026).

1. Baseline Audit July 2025

Retrospective review of 13 records. Data collection focused specifically on **Admission Medications** to capture the baseline prescribing status at the point of hospital entry, providing an objective benchmark.

2. The Intervention CORE

Established a **monthly Multidisciplinary Team (MDT)** meeting to systematically review prescriptions, bringing together:

- **POA Ward Doctor:** Providing psychiatric context and symptom history.
- **MOE Consultant:** Providing specialist geriatric perspective on physical health and frailty.
- **Clinical Pharmacist:** Ensuring pharmacological accuracy and identifying drug-drug interactions.

Action: Systematic screening against STOPP/START v3.

3. Re-Audit Jan 2026

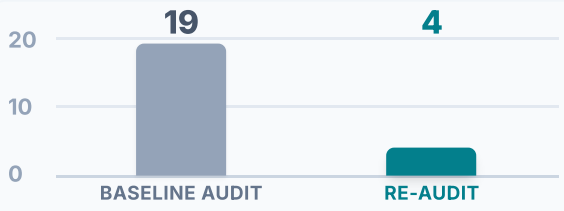
Follow-up review of 14 patient records 6 months later. Reviewed current medications to measure the longitudinal impact of the monthly meetings.

4. Routine Integration

Embedding the MDT structure into routine clinical governance. This ensures continuous, active medication rationalisation becomes the standard of care.

3 QUANTITATIVE IMPACT

The re-audit cohort was more complex, with a total medication count nearly double that of the baseline (**161 vs. 85**). However, the absolute number of inappropriate items fell from 19 to 4 (**22.35% to 2.48%; p<0.0001**). This suggests that while patients required more medication, the meeting functioned as a potent clinical filter.



ABSOLUTE REDUCTION
-19.87%

RELATIVE REDUCTION
88.89%

4 KEY PRESCRIBING CHANGES

The reduction in inappropriate medication was driven primarily by cessation of:

VITAMIN THERAPY

Stopping vitamins (Folic Acid, Colecalciferol) where an adequate course had been completed or repeat biochemistry normal. (NICE, 2022).

CARDIOVASCULAR

Stopping statins and antihypertensives in patients exhibiting severe physical frailty.

CNS DEPRESSANTS

Actively tapering sedatives and analgesia that had become regularised in the community.

GASTROINTESTINAL

Stopping long-term Proton Pump Inhibitors where no longer indicated.

5 HOLISTIC CLINICAL BENEFITS

Beyond pharmacology, the formal POA-MOE link offers wide systemic benefits:

- **Mitigating Diagnostic Overshadowing:** The presence of a geriatrician helps ensure that physical symptoms are not mistakenly attributed to psychiatric conditions.
- **Comprehensive Frailty Management:** Collaborative reviews facilitate the early identification of frailty syndromes, allowing for proactive interventions.
- **Optimised Physical Comorbidities:** Improved management of chronic conditions (Heart Failure, COPD, Diabetes) alongside mental health.
- **Shared Decision Making:** Robust clinical decision-making regarding the "burden of treatment" versus quality of life in advanced dementia.

6 NHS SUSTAINABILITY

This project contributes to the long-term sustainability of the NHS in three key areas:

CLINICAL IMPACT

Medication rationalisation lowers risks of falls & delirium, preserving independence.

FINANCIAL SAVINGS

Each fall-related hip fracture costs the NHS on average £14,642 (Baji et al., 2023).

ENVIRONMENTAL

Lowering unnecessary prescribing and wastage aligns perfectly with our Net Zero ambitions.

7 CONCLUSION AND RECOMMENDATIONS

"By bridging the gap between psychiatry and geriatric medicine, we have transformed our local prescribing culture from one of 'passive maintenance' to 'active rationalisation'."

1. **Formalise POA-MOE Link:** Every ward should have a designated consultant "link" for structured monthly multidisciplinary reviews.
2. **Active Vitamin Monitoring:** Implement strict time-limited prescribing protocols unless justified by repeat biochemistry.
3. **Standardise Training:** Incorporate STOPP/START criteria into the induction for all rotating medical and pharmacy staff.
4. **Digital Integration:** Embed decision-support tools into electronic prescribing systems to automatically flag inappropriate meds.

REFERENCES

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