EMR template text for the Soap Note when seeing a patient for Polypharmacy / Deprescribing (includes references)

***** *An important note that this template is intended for use by healthcare practitioners. If you are a healthcare practitioner, please recognize that you should use caution to adapt the material to be most appropriate to your practice scenario, the patient in front of you, and any licensing requirements you are subject to. Check the dates on the materials, and make sure that they are still relevant. I assume no responsibility for use of these materials, and share them here in the spirit of collaboration and increasing open access to primary care learning and practice tools.*

REASON WE ARE CONSIDERING DEPRESCRIBING:
Pt request /
Adverse effects noted /
Polypharmacy noted, regular meds = XX /
Prognosis changed or limited /
Possible harmful drug interaction /
Contravention of CPSBC guideline /
Medication no longer indicated /
Other: describe

CURRENT MEDICATIONS:
See "Other Meds" / refer to other location where current med list exists, or list:
MED NAME / DOSE / FREQUENCY / INDICATION / TARGET / COMMENTS

PATIENT/FAMILY REPORTED POSSIBLE MEDICATION HARMS:
Adverse effects:
None / pain / change to vision / decreased alertness / memory loss / dry mouth / sexual dysfunction / sedation / depression / fatigue / dizziness // details:

Pill Burden:
pills taken per day = PP // Number of times per day medications need to be taken = OD / BID / TID / QID / >5x/d

Excessive effect:
None / SBP << target / A1c << target / other:

Financial Burden:
None / cost of medications per month = $$$, reasonable lower priced alternatives available / not available.

Unknown indication:
Reason for prescribing is not known, patient perceives no benefit from the medicine

COMMUNICATION ABILITY:
Preferred language: English / Other: GG
Ability to comprehend English: Yes/ Some/ None /Don't know
Vision: normal/ impaired/ blind
Hearing: normal/ impaired / deaf
Ability to communicate immediate needs/comfort: excellent / impaired / absent

COGNITION/FRAILTY:
Dementia: XX/7 (Global deterioration score)
Frailty: YY/9 (CHSA-CFS)
Mobility: excellent / impaired / cane / walker / WC / bed bound

CONCURRENT MEDICAL CONDITIONS:
SYMPTOMATIC:
joint pain - absent, stable, unstable // details:
anxiety/depression- absent, stable, unstable // details:
insomnia- absent, stable, unstable // details:
agitation- absent, stable, unstable // details:
heartburn - absent, stable, unstable // details:
other: details

ASYMPTOMATIC RISK FACTOR CONDITIONS:
hypertension - BP Tru or equiv BP estimate: SSS/DD // untreated / treated with:
atrial fibrillation - anticoagulated with FFFF / untreated / treated with:
elevated A1c - current GG% / symptoms of HYPOglycemia present / symptoms of HYPERglycemia present, untreated / treated with:
elevated cholesterol – untreated / treated
other:

RELEVANT MEDICAL HX:
past CV events: stroke (year) / MI (year) / cardiac stents (year)
past cancer: type (year)
Estimate of future CV event risks: not applicable due to co morbidity or age >74 // Framingham risk = JJ%
other:

PROGNOSIS AND ADVANCE CARE PLAN INFO:
Patient is likely to experience a normal Cdn life expectancy (~men = 80, women = 84)
OR
Patient is already past the normal Cdn life expectancy, but HEALTHY, so may be reasonable to expect to live an additional XX years (https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310013401)
OR
Patient is past the normal life expectancy and has multiple health challenges, I would not be surprised if they were to die in the next 12 months.
OR
Patient has multiple SEVERE health challenges//KNOWN LIFE LIMITING ILLNESS: (describe) , I would not be surprised if they were to die in the next 12 months.

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Patient is aware of this prognosis: yes/no, comments:
Family/loved one is aware of this prognosis: yes/no, comments:

Advanced care plans discussed? reason why not / located:
Serious Illness conversation completed? reason why not / located:
Preferred SUBSTITUTE DECISION MAKER identified: ddddd dddd OR
ACTING SUBSTITUTE DECISION MAKER is: ddddd dddd

PATIENT PERSPECTIVE/ PREFERENCES
Patient's current perspective on deprescribing:
Unable to articulate: due to dementia / other

FAMILY PERSPECTIVE:
Not required, patient able to inform all own health decisions. / Is worried about specific drugs: / Trusts me (doctor) to give specific advice / Has expectations unrealistic to patients condition/ Has limitations in understanding about ability of medicines to prevent death or disability, details: / other:

***DEPRESCRIBING PLAN:

1/ Goal of deprescribing:
Have patient feel better able to meet their daily goals, per patient / family member / nurse report. //
Reduce number of medications //
Reduce cost to patient of medications //
Improve specific body/mind function: describe //
Increase sense of well-being //
Align medical therapy with prognosis //
Align medical therapy with patient preferences //

2/ Patient and or family agree with the goal and understand both the possible benefits and harms of making this decision:
Patient could feel better, as per goal identified above //
Patient could have adverse effect as outlined below in 5,6,7: //
We have limited research to give an accurate estimate of how this particular patient could be affected either positively or negatively by the medications, and either prescribing or deprescribing may have an unintended serious negative effect, including heart attack, stroke or death. We have reviewed what we think is best for this patient as of today, should patient condition/experience/preference change or new research be available, we might change this deprescribing decision.

3/ Changes made to medication today:

Drug name / action: discontinued // decreased dose / frequency // increased dose //

4/ When to be reviewed for effect:
1-7 days //
2-4 weeks //
4-12 weeks //
Other interval:

5/ Possible negative consequences from this change, reviewed with patient/ family / nurse:
Increase in symptoms: pain, dizziness, fatigue, shortness of breath, anxiety, other:
AND/OR
New symptoms: pain, dizziness, fatigue, shortness of breath, anxiety, other:

6/ How patient / family / nurse can advise if change is causing negative effects:
Book an appointment // call me // email me

7/ Instructions given to patient/ family/ nurse about when to seek emergency medical attention:
Unable to breathe properly, extreme symptoms not relieved by any mechanism previously discussed (e.g. use of nitro spray for chest pain or slow deep breathing for anxiety), loss of consciousness, other reasons that you are fearful of that cannot wait until you can be seen by me as soon as I am available.

8/ Next change(s) proposed for deprescribing plan, to be addressed at future visit:

Drug name / action: discontinued // decreased dose / frequency // increased dose // GOAL OF MAKING THIS CHANGE Have patient feel better able to meet their daily goals, per patient / family member / nurse report. //Reduce number of medications // Reduce cost to patient of medications // Improve specific body/mind function: describe //Increase sense of well-being // Align medical therapy with prognosis // Align medical therapy with patient preferences //

9/ Additional thoughts or comments that I have about this plan:
None // concerned about patient's ability to report improvements or deterioration // others:

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COLLEAGUES CONSULTED in making this plan:
Family medicine colleague: details
RACE MD: details
Pharmacist: details
Other: details

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REFERENCES REVIEWED / TOOLS ACCESSED in the preparation of this plan:

https://www.ti.ubc.ca/2014/09/02/reducing-polypharmacy-a-logical-approach/

CV DRUGS for low risk patients
Luymes CH, Poortvliet RKE, van Geloven N, de Waal MWM, Drewes YM, Blom JW, et al. Deprescribing preventive cardiovascular medication in patients with predicted low cardiovascular disease risk in general practice - the ECSTATIC study: a cluster randomised non-inferiority trial. BMC Med. 2018 11;16(1):5.

HYPERTENSION:
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https://www.ti.ubc.ca/2017/09/15/106-using-best-evidence-management-hypertension/

DIABETES:
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Mallery LH, Ransom T, Steeves B, Cook B, Dunbar P, Moorhouse P. Evidence-Informed Guidelines for Treating Frail Older Adults With Type 2 Diabetes: From the Diabetes Care Program of Nova Scotia (DCPNS) and the Palliative and Therapeutic Harmonization (PATH) Program. Journal of the American Medical Directors Association. 2013 Nov 1;14(11):801–8.

https://www.ti.ubc.ca/2017/11/20/107-empa-reg-outcome-trial-what-does-it-mean/

https://www.ti.ubc.ca/2017/03/15/103-current-glucocentric-approach-management-type-2-diabetes-misguided/

https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/provincial-academic-detailing-service/pad_glucose_lowering_medications_booklet.pdf

GERD:
https://www.ti.ubc.ca/2018/06/26/111-deprescribing-proton-pump-inhibitors/

OSTEOPOROSIS:

https://www.ti.ubc.ca/2011/02/23/bisphosphonates-do-they-prevent-or-cause-bone-fractures/

FRAIL ELDERS:
Potter K, Flicker L, Page A, Etherton-Beer C. Deprescribing in Frail Older People: A Randomised Controlled Trial. PLoS ONE. 2016;11(3):e0149984.

Wouters H, Scheper J, Koning H, Brouwer C, Twisk JW, van der Meer H, et al. Discontinuing Inappropriate Medication Use in Nursing Home Residents: A Cluster Randomized Controlled Trial. Annals of Internal Medicine [Internet]. 2017 Oct 10; Available from: http://annals.org.ezproxy.library.ubc.ca/article.aspx?doi=10.7326/M16-2729

LIFE LIMITING ILLNESS:
Todd A, Husband A, Andrew I, Pearson S-A, Lindsey L, Holmes H. Inappropriate prescribing of preventative medication in patients with life-limiting illness: a systematic review. BMJ Support Palliat Care. 2016 Jan 5;