Older people: completing your learning experience

A CPPE distance learning programme

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Older people: completing your learning experience

Answers and suggestions for putting your learning into practice

Educational solutions for the NHS pharmacy workforce

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Having worked through the Older people distance learning programme, you now have an opportunity to compare your answers to the exercises and reflective questions with the suggested answers provided here.

These suggested answers are not intended to be comprehensive; you should refer to other resources indicated, as well as local guidelines when considering your responses.

Aim

The aim of this learning programme is to update your knowledge on the changes that come with ageing and the impact these have on health and medicines use for older people. You will also learn about the roles of the multidisciplinary teams who provide care for older people and how pharmacy can link in with them to optimise health outcomes for older people.

Learning objectives

You can use our programmes to support you in building the evidence that you need for the different competency frameworks that apply across your career. These will include building evidence for your Foundation pharmacy framework (FPF), demonstrating development as your career progresses with the Knowledge and skills framework (KSF) and supporting your progression through the membership stages of the Royal Pharmaceutical Society (RPS) Faculty.

As you work through the programme consider which competencies you are meeting and the level at which you meet these. What extra steps could you take to extend your learning in these key areas?

After completing this distance learning programme, you should be able to:

- explain the importance of taking a person-centred approach to support older people with their medicines use, which reflects the differing needs of older people; especially those who are frail or have mental health problems
- outline the various healthcare settings commonly used by older people, the role of various people who provide care for older people, and the role of pharmacy in supporting the safe transfer of care between settings
- describe the impact of the physical, behavioural and socio-economic challenges faced by older people on their use of medicines and how pharmacy services can support medicines optimisation
- describe the effects of ageing on the pharmacokinetics and pharmacodynamics of medicines and the causes and consequences of polypharmacy
- outline the role of the pharmacy team in safeguarding vulnerable older people.

Feedback

We hope you find this learning programme useful for your practice. Please help us to assess its value and effectiveness by visiting the my CPPE page on our website: www.cppe.ac.uk/mycppe

Alternatively, please email us at: feedback@cppe.ac.uk

All web links in this document were accessed on 17 April 2015
Answers to exercises

Exercise 1 (page 8)
A number of changes to physical and mental health can affect a person’s ability to take their medicines. Once you have considered the implications of each, list the actions you can take to support older people.

Visual impairment
- Offer large print labels and patient information leaflets (PILs) (X-pil website)
- Use sans-serif fonts, eg, Arial on pastel-coloured backgrounds in the largest possible font size, ideally 20 pt
- Make sure the lighting is good where you use or give written information
- Use the RNIB service to access stickers, Braille PILs, etc
- Talking (voice recording) labels are available but need to be transferred to new supplies of medicines after each dispensing
- Supply the same brand consistently where possible to ensure familiarity with packaging
- Make sure people have regular eye tests and their glasses are available to them and cleaned

Hearing impairment
- Use hearing loops, if available, to enable hearing aid users to hear more effectively without the background distortion
- Position yourself in front of the patient, three to six feet away
- Minimise background noise by turning off the television, radio, etc
- Wait until the patient can see you before you start speaking, make sure your face is well lit
- Position yourself on the side of the person’s strongest ear
- Use short, simple sentences
- If your message is not getting through, rephrase it but speak more clearly and slowly, rather than more loudly
- Write things down for the patient to take away as a back-up
- The person may be better able to understand the voice of their relative or well-known carer; ask them to help you with the conversation
- Help people to manage their hearing aids and encourage them to use them. If they have arthritis or sight problems they may have problems simply inserting the batteries, so offer to help them with this.

Swallowing difficulties
- Ensure the most appropriate formulation has been prescribed, eg, small tablets, scored tablets, soluble tablets, liquid preparations
- Consider thickeners if appropriate
- Contact pharmaceutical companies as they may have information on file that will help with medicines administration (off-label)
- Source ‘specials’ only as a last resort as their clinical efficacy has rarely been demonstrated
Mobility

- Offer domiciliary medicines use reviews and telephone consultations. Your local area team may grant approval for domiciliary services.
- Liaise with community intermediate care teams when patients are discharged to ensure medicines are reviewed in the person’s home.
- Offer home delivery or liaise with a family member or carer who can collect medicines.
- Consider side-effects of prescribed medicines, especially antipsychotics, anticholinergics and sedatives, which are linked to falls.

Manual dexterity

- Ensure patients are assessed and the most appropriate solutions offered to assist them with their medicine taking and enable them to maintain their independence.
- Use immediate release morphine tablets for breakthrough pain rather than morphine liquid, for people with reduced strength in their hands.
- Refer patients to the physiotherapy unit to be assessed for support in the home.
- If you decide not to use non-child resistant closures ensure you give advice on storing medicines out of reach of visiting children.
- Fit medicinal aids to tubes or inhalers and pre-load Respimat® inhaler cartridges for older patients when they collect their prescription.

Cognitive impairment

- Minimise the tablet burden as far as possible (see Section 4.3 of the learning programme for more information on polypharmacy).
- Provide reminder charts to cognitively intact patients who have had several changes to their medicines, or who may forget what each of the medicines is for.
- Consider suitable medicines compliance aids (MCAs).
- Involve patients in decisions about their medicines, using a person-centred consultation style.
- Involve paid or unpaid carers to ensure their support and understanding.
- Reminder phone call services, such as Carecalls.co.uk are available or, for older people who do have the technology, there are apps on smartphones that may be helpful.

Further learning

The CPPE e-learning programme, Supporting patients to get the most from their medicines, provides a large amount of information about possible solutions to meet specific needs. Find out more at: www.cppe.ac.uk/e-learning
Rachel Wilmot is a 76-year-old lady with severe disability, due to multi-joint osteoarthritis. She tells you she has itching due to dry skin, which is worse at night and is beginning to disturb her sleep.

She spoke to the doctor and he prescribed a tub of E45 cream with a pump dispenser, but she can’t use it as she can’t depress the pump. She asks you if you can give her a tablet.

What suggestions would you make?

- Advise her that she may not need a tablet for the itch if you can find a cream she can use more easily.
- Check whether she thinks she could use a tub or tube and, if so, consider the available forms of alternative emollients. If you find a suitable option, you could suggest it to the GP. Note that a ‘key’ is available for tubes, to help people squeeze out the cream.
- Advise her she should use the cream regularly, up to four times a day, as required.
- Advise her to use an emollient wash product or bath oil, preferably in addition to the cream, although these products may increase the risk of slipping, so care is advised.
- Ensure the itching is not the result of an adverse drug reaction or another identifiable cause that could be addressed (for example, the use of aqueous cream BP or other product containing sodium lauryl sulfate (SLS), a change in her usual detergent/bath product, bathing in hot water, hypothyroidism).
- Find out if she has help at home; perhaps someone can help apply the cream. Cream/ointment applicators are available to purchase from medical device manufacturers, but a person with arthritis could find them difficult to manipulate and use.
**Exercise 3** (page 12)

The table below lists areas in which pharmacy could provide support for older people to help them maintain their wellbeing and remain independent for as long as possible.

For each area consider what the challenges are for older people and their carers. What advice and services do you or could you provide in your role? Where do you or could you signpost people to for further support?

<table>
<thead>
<tr>
<th>Advice area</th>
<th>Advice and services</th>
<th>Signposting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>Advise on healthy eating, especially if malnourished or overweight</td>
<td>Local dietitian services, meals on wheels, Age UK</td>
</tr>
<tr>
<td>Exercise</td>
<td>Explain that it is important to keep moving, little and often. Exercise is good for general health and also beneficial in dementia and COPD</td>
<td>Swimming pool, over 65s classes at local gyms</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Raise awareness about staying within healthy limits of alcohol intake</td>
<td>Local alcohol services, if required</td>
</tr>
<tr>
<td>Smoking</td>
<td>Explain that a person is never too old to quit. Stopping is still of benefit in later life, especially for people with COPD. Offer a stop smoking service or refer into a local one</td>
<td>GP-led smoking cessation programmes, if not running in your pharmacy or another one locally</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Encourage people to maintain contact with others, either face to face, by phone or, if they prefer, online</td>
<td>Day centres, community centres, online forums, local or national befriending schemes, Women’s Institute, Age UK</td>
</tr>
<tr>
<td>Self-care</td>
<td>Provide information about living with long-term conditions. Offer NHS health checks for people who are eligible. Advise on minor ailments and when to seek help</td>
<td><a href="http://www.nhs.uk/Livewell/Pharmacy/Pages/early-advice-pharmacy-minor-illness.aspx">www.nhs.uk/Livewell/Pharmacy/Pages/early-advice-pharmacy-minor-illness.aspx</a></td>
</tr>
<tr>
<td>Winter health</td>
<td>Support winter health campaigns. Offer flu and pneumococcal jabs for older people and flu jabs for their carers. Provide advice on the risk of cold homes – make sure older people are aware of the winter fuel allowance</td>
<td>Age UK, NHS Choices, <a href="http://www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx">www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx</a></td>
</tr>
<tr>
<td>Access to medicines</td>
<td>Home delivery. Reordering of repeat medicines</td>
<td></td>
</tr>
</tbody>
</table>
Exercise 4 (page 17)
Josephine Boeber, an 80-year old lady with hypothyroidism and dietary controlled type 2 diabetes was admitted to hospital a week ago following a fall. On admission she was taking thyroxine and paracetamol, for knee pain, when necessary. On examination Josephine had high blood pressure and she has been prescribed ramipril 5 mg daily. Josephine weighs 54 kg and her serum creatinine (from bloods taken 12 hours ago) is 110 micromols/Litre.

What action, if any, would you take?

Drug choice
For high blood pressure, a diuretic or calcium channel blocker would be common first choices in older people, but as this patient is diabetic, an ACE inhibitor is probably a good choice.

Initiation
She has mild renal impairment: her glomerular filtration rate (GFR) is 29 mL/min. The initial dose of ramipril should be 1.25 mg daily, increased at intervals of one to two weeks, to a maximum of 5 mg (as per the British National Formulary). Her renal function should be monitored, ie, re-tested in a week’s time.

Caution: there is a risk of postural hypotension with the first dose.

Effectiveness and side-effects
Monitor blood pressure and assess side-effects. Check renal function and electrolytes (especially potassium) with each dose increase, and then regularly.

Exercise 5 (page 19)
Harold Ostenbrook is an 87-year-old gentleman who has Parkinson’s. Yesterday, your delivery driver found him on the floor in his hallway. He was conscious, but had fallen and was unable to get up. He was admitted to hospital with hypothermia and a fractured wrist.

He has been taking the following medicines:
- ramipril capsules 5 mg, daily
- co-codamol tablets 30/500 mg, two four times a day
- nitrazepam tablets 5 mg, at night
- co-careldopa tablets 100/25, four times daily.

What pharmacokinetic and pharmacodynamic factors could have potentially contributed to this incident? What changes, if any, would you suggest are made to his medicines?

Pharmacokinetic
Nitrazepam is a long-acting, renally excreted benzodiazepine; with age-associated declining renal function, the half-life lengthens and increases the risk of drowsiness and falls.

Speak with Harold (or his carer) about the risks of continuing therapy and consider withdrawal. If he needs something to help him sleep, zopiclone 3.75 mg or a short-acting benzodiazepine (eg, temazepam 10 mg) would be a more reasonable choice. Depending on the action you agree with the patient, you may need to monitor for withdrawal effects.

Pharmacodynamic
An increased sensitivity of benzodiazepine receptors could result in nitrazepam having an exaggerated sedative effect, leading to greater risks of falls. There is a
risk of postural hypotension due to ramipril. Check the patient’s blood pressure and assess the continued need for ramipril. Codeine may increase drowsiness and balance problems, which may lead to falls. Opioids may also increase the risk of hypothermia. Consider a change to paracetamol.

Co-careldopa predisposes patients to drowsiness, low blood pressure and falls. Consider how well the patient’s Parkinson’s is controlled and refer to their Parkinson’s specialist if side-effects are present or disease control is sub-optimal.

Exercise 6 (page 20)
What are the factors that lead to polypharmacy?

- The availability of new drugs to treat previously untreatable conditions
- The availability of more drugs without prescription and over the internet
- People are living longer and therefore have more long-term conditions that require treatment with medicines
- Prescribing in secondary and primary care
  Older people with multiple conditions may be seen at a range of specialist centres by various healthcare professionals, all of whom may prescribe medicines, with little communication with the patient’s GP who is then reluctant to change or discontinue medicines started by consultants, possibly because they have not been provided with information on the rationale behind the prescribing, and/or they don’t want to jeopardise relationships.
- Adverse drug reactions (ADRs) are treated with new medicines
  A ‘prescribing cascade’ is a misinterpretation of an adverse drug reaction to one medicine, assuming it is a new medical condition, leading to the subsequent inappropriate prescribing of a second medicine. To reduce the chances of a prescribing cascade, any new signs and symptoms should be considered as a possible consequence of current treatment. Some examples of prescribing cascades common in older people are outlined in the table below.

<table>
<thead>
<tr>
<th>Current medicines</th>
<th>Misinterpreted ADR</th>
<th>Medication initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoclopramide</td>
<td>Parkinson’s symptoms</td>
<td>Levodopa</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Hypertension</td>
<td>Antihypertensives</td>
</tr>
<tr>
<td>Pseudoephedrine</td>
<td>Urinary retention</td>
<td>Tamsulosin</td>
</tr>
</tbody>
</table>

- Demands of patients and carers
  Less commonly, polypharmacy can result from the demands to initiate medicines from older people themselves, or their carers, or other health staff. Common examples in practice include requests for sip feeds by relatives and care homes staff, antipsychotics and sleeping pills by care home staff, and glucosamine by older people.

- Lack of review for efficacy after starting medicines
  A good example of this is medicines for urinary incontinence; these medicines do not work for all people and, at best, produce modest reductions in numbers of episodes of incontinence. A four to six week trial is sufficient to assess their efficacy, but many people are never reviewed and end up with long-term anticholinergic prescriptions that cause cognitive impairment or mobility problems, without helping their urinary symptoms.
**Exercise 7** (page 22)

What medicines commonly used by older people can cause the following side-effects?

<table>
<thead>
<tr>
<th>Side-effects</th>
<th>Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Opioids, antimuscarinics, antidepressants, dopaminergics, calcium channel blockers, bisphosphonates, ferrous sulphate, calcium</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>Opioids, cytotoxics, donepezil, rivastigmine, nefopam, riluzole, dopaminergics, zopiclone, metformin</td>
</tr>
<tr>
<td>Postural hypotension, falls</td>
<td>Diuretics, benzodiazepines, ACE inhibitors, antihypertensives, levodopa, alpha-blockers, psychotropics, tricyclics, opiates</td>
</tr>
<tr>
<td>Impaired cognition</td>
<td>Fentanyl, citalopram, fluoxetine, oxybutinin, opiates, cimetidine, antiepileptics</td>
</tr>
<tr>
<td>Blood disorders</td>
<td>Carbamazepine, H2 receptor antagonists, aminosalicylates, riluzole, mirtazepine, trimethoprim, carbimazole, phenytoin, methotrexate</td>
</tr>
<tr>
<td>Gastrointestinal bleeds</td>
<td>NSAIDs, including coxibs, SSRIs, aspirin, clopidogrel, dipyridamole</td>
</tr>
<tr>
<td>Confusion</td>
<td>Levodopa, anticholinergics, dopaminergics, nefopam, spironolactone, codeine, tramadol</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>Antimuscarinics, nefopam, carbamazepine</td>
</tr>
<tr>
<td>Renal failure</td>
<td>NSAIDs, including coxibs, ACE inhibitors, lithium, angiotensin-II blockers, aminoglycosides, diuretics</td>
</tr>
<tr>
<td>Hypertension</td>
<td>NSAIDs, including coxibs, sympathomimetics, sibutramine</td>
</tr>
<tr>
<td>Extrapyramidal effects</td>
<td>Metoclopramide, antipsychotics, donepezil</td>
</tr>
</tbody>
</table>
Reflective question (page 32)
Why might shared decision making be more difficult for older people?

- They might have dementia or other form of cognitive impairment that makes it difficult for them to retain information and give informed consent.
- Many older people have been brought up with the idea that health professionals are ‘all-knowing’ so they prefer a paternalistic approach and passive role in decision making.
- They may be being looked after by more than one consultant.
- They may have multiple or complex medical conditions or be on complex treatment regimens.
- They may have a physical disability preventing them from visiting their hospital/pharmacy/GP practice/clinic.
- Their religious or ethical beliefs may affect their decision making regarding medicines and healthcare.
- They may be housebound and rely on carers to have any conversations with healthcare professionals.
- They might not have the literary skills to read or interpret the information given to them, or there may be language barriers.
- Their condition might be causing stress that makes it difficult for them to make a decision.
- They might not have a support network of people to talk over the options with or bounce ideas off to come to a decision.

Exercise 10 (page 44)
Dorothy Andersen is a 79-year-old lady who has requested a medicines use review (MUR) with you. From your discussion and medicines records, you gather the information set out below.

<table>
<thead>
<tr>
<th>Medicines information</th>
<th>Mrs Andersen’s account of what she takes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bendroflumethazide 2.5 mg daily</td>
<td>She takes them in the mornings, but misses her dose on Mondays, Wednesdays and Saturdays. This is because she attends the social club on Monday and Wednesday, and her nephew takes her shopping on Saturday morning. She doesn’t want the water tablets to cause her to have an ‘accident’ during the journey.</td>
</tr>
<tr>
<td>Simvastatin 40 mg at night (initiated a month ago)</td>
<td>She doesn’t take this medicine at all because she is worried the strength is too high. She was taking atorvastatin 10 mg and the GP changed it last month to these new pills which are four times the strength!</td>
</tr>
<tr>
<td>Paracetamol 500 mg to 1 g four times a day, as required</td>
<td>These are supposed to be for her knee pain but they don’t help much. She’s also worried that if she uses them too much she could become ‘dependent’ on them. She only takes one tablet every now and again when her pain is so severe that she can’t walk.</td>
</tr>
</tbody>
</table>

1. What do you think about her reasons for not taking the medicines?

They are justified; just because they are not all factual or do not align with professional views does not make them invalid.
A patient’s views and perceptions affect whether or not they start or continue
Older people: completing your learning experience

taking their medicines. Where views are based on misconceptions, you can provide the patient with appropriate information; once this is done, the patient’s perspective may change.

2. How would you respond to the issues raised in the review?

Establish how much Dorothy wants to be involved in decision making and use an effective communication approach to encourage her to contribute.

Clarify her concerns, beliefs and expectations about her medicines.

You should check whether her current medicines regimen of bendroflumethiazide is adequately controlling her blood pressure. If daily dosing is needed, on the days when she goes out she could try to take the doses either two hours before leaving, or when she gets back (providing it is no later than around midday). You may be able to give her some peace of mind by finding out whether there are public toilets in the shopping centre.

Explain that the simvastatin dose is roughly equivalent to the atorvastatin dose she was taking. Explain the possible reason for the change of statin, for example, perhaps atorvastatin didn’t work adequately or caused side-effects.

Explain that paracetamol is not addictive. For each dose, she should take two tablets to get the full painkilling effect. It is best not to wait until the pain is severe to take her dose; in fact, it may help prevent the pain if she takes them regularly.

Aim to develop a care plan for ongoing treatment, in agreement with Dorothy.

3. After the medicines use review, what recommendations for action would you make?

If necessary, suggest an alternative dosing regimen for bendroflumethiazide. It may be necessary to consider changing to another medicine if needed; for example, a calcium channel blocker.

If she would prefer not to take simvastatin, suggest it is changed back to atorvastatin, as this is in line with current NICE guidance (provided it wasn’t changed due to ineffectiveness or side-effects).

It may be helpful if the GP also reassures Dorothy.
Exercise 11 (page 46)

Older people who experience pain may need to be prescribed analgesics. There are a number of possible choices, and each has its advantages and disadvantages. Complete the following table, bearing in mind what you have learnt about polypharmacy, adverse drug reactions and medicines adherence.

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paracetamol</strong></td>
<td>Effective in mild to moderate pain</td>
<td>Only effective in mild to moderate pain, and no anti-inflammatory effect</td>
</tr>
<tr>
<td></td>
<td>Few side-effects compared with other analgesics</td>
<td>Doses usually not optimised; need to be taken regularly for best effect</td>
</tr>
<tr>
<td></td>
<td>Cheap</td>
<td>Lots of tablets to take</td>
</tr>
<tr>
<td></td>
<td>Variety of formulations</td>
<td>Soluble tablets have high salt content</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overdose potential</td>
</tr>
<tr>
<td><strong>Opiates</strong></td>
<td>Effective in moderate to severe pain</td>
<td>Drowsiness</td>
</tr>
<tr>
<td></td>
<td>Variety of choices and formulations, eg, patches, tablets</td>
<td>Nausea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tolerance and dependence</td>
</tr>
<tr>
<td><strong>Combinations of</strong></td>
<td>Effective in moderate pain</td>
<td>Drowsiness</td>
</tr>
<tr>
<td><strong>paracetamol and</strong></td>
<td>Simplified dosing regime</td>
<td>Constipation</td>
</tr>
<tr>
<td><strong>opiates</strong></td>
<td></td>
<td>Doses often not optimised</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dose is inflexible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk of overdose if more than one combination prescribed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More expensive</td>
</tr>
<tr>
<td><strong>NSAIDs</strong></td>
<td>Effective analgesic and anti-inflammatory</td>
<td>Risk of renal, cardiovascular, gastrointestinal and skin adverse reactions</td>
</tr>
<tr>
<td></td>
<td>Topical preparations available and other formulations, eg, suppositories</td>
<td></td>
</tr>
<tr>
<td><strong>Amitriptyline</strong></td>
<td>Can be used for neuropathic pain</td>
<td>Unlicensed</td>
</tr>
<tr>
<td></td>
<td>May help sleep</td>
<td>Side-effects, including confusion, drowsiness, constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People may worry about taking an antidepressant (even though it is for pain)</td>
</tr>
<tr>
<td><strong>Gabapentin</strong></td>
<td>Effective for neuropathic pain</td>
<td>Caution in renal impairment: need to reduce dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use with caution in elderly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Side-effects include confusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May rarely precipitate renal failure</td>
</tr>
</tbody>
</table>
### Exercise 12 (page 48)
What groups of older people may be of particular risk of abuse or neglect?

Anyone can be abused or neglected, however, those at particular risk include:
- isolated older people with little support or family
- people with mental health problems, such as dementia or depression
- frail people with little mobility, particularly those who are bed-bound
- people with partial or no sight or hearing
- people living in care homes
- older people who are illiterate
- people who rely on others to make financial decisions for them.
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