Patient Centered Care Assignment
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Mrs J is a 90-year female who presented to hospital with a concussion after a fall. Mrs J is widowed, but lives independently at home with the support of her neighbouring daughters. She reports having recent falls at home.

Mrs J's medical history includes atrial fibrillation, hypertension, dyslipidaemia, macular degeneration, spinal osteoarthritis, hearing impairment and CKD stage 4 with a baseline CrCl ~ 20mL/min. Mrs J has reasonable health literacy, reports compliance to her blister-packed medications, and has very positive outlook life and her health in general.

Medications prior to admission:

- Diltiazem CD 180mg mane
- Metoprolol CR 142.5mg mane
- Cilazapril 2.5mg mane
- Bendroflumethiazide 1.25mg mane
- Atorvastatin 20mg mane
- Colecalciferol 1.25mg monthly
- Paracetamol 1g TDS
- Fish oil 1000mg mane
- Warfarin (marevan)
    - Target INR 2-3
    - Usual dose 3mg nocte

Multiple blood pressure readings during her admission reflected a significant postural drop, indicating postural hypotension – a potential contributing factor to her recent falls. Upon assessment, Mrs J has a high falls risk - including polypharmacy with multiple anti-hypertensives, her visual and hearing impairment, and reduced mobility with her osteoarthritis. A further complication from her high falls risk is an increased bleeding risk due to warfarin anticoagulation therapy.

Given Mrs J's age and falls risk, tight blood pressure control could cause more potential harm than benefit. Low dose bendroflumethiazide, given Mrs J's renal impairment, will have minimal effect as a diuretic, but may still contribute to her postural drop. Low dose cilazapril could also contribute to postural hypotension. Hence my recommendation is for Mrs J to remain on her beta-blocker and calcium channel blocker (given her hypertension and need for rate control for her AF), and to adopt a non-intensive systolic blood pressure target <140mmHg.We monitored Mrs J's blood pressure and postural drop during her hospital admission after adapting these recommendations, and noted no significant change in her blood pressure, but a reduction in postural drop. Mrs J also noticed a difference upon standing, and felt steadier on her feet.

Contributing to Mrs J's risk of falls is her debilitating lower back pain. With limited analgesia options due to her renal impairment, I recommended increasing her regular paracetamol dosing to 1gram QID (weight >50kg). Mrs J noticed a decrease in her pain levels during her hospital admission on this regular dosing.

Considering Mrs J's polypharmacy, I also suggested a review of her atorvastatin for primary prevention by her GP. There is a lack of clear evidence for the net benefits of statin therapy for primary prevention in the elderly, and continuation could increase the risk of adverse reactions.

At Mrs J's home visit we discussed some non-pharmacological recommendations for her to try at home to prevent postural hypotension. Mrs J reported minimal fluid intake at home, so I

encouraged her to aim for at least 1L of water a day; to help maintain her blood pressure and to prevent acute renal impairment from dehydration. I also discussed standing up slowly when getting out of bed.

Mrs J's daughter was present at the home visit, so I took the opportunity to provide warfarin education. I asked Mrs J and her daughter to demonstrate how she manages her medication, in particular her warfarin regimen at home with her impaired vision. I also provided Mrs J with a brightly coloured medication card displaying large pictures of her regular medication for easy recognition.

It was an absolute pleasure meeting Mrs J and her daughter. It was eye opening to see how integrated the various health professions are in working towards the same goal. The assignment gave me a greater understanding of the role of a pharmacist; I could see the direct influence of my small interventions and saw a massive impact on Mrs J's quality of life.