Guidance for the Prescribing and Administration of *As required* Oral Psychotropic Medication in Mental Health & Learning Disability Inpatient Services

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Consultation and distribution	
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Guidance for the Prescribing and Administration of *As required* Oral Psychotropic Medication in Mental Health & Learning Disability Inpatient Services

Scope

The following guidance describes a good practice model for the use of *as required* oral psychotropic medication within **all mental health and learning disability inpatient settings in NHS Lanarkshire**.

Clinical judgement should be exercised on the applicability of any guideline, influenced by patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty. If there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

For use of psychotropic medication in the management of delirium, refer to local delirium guidance.[1]

Introduction

The use of '*as required*' or 'prn' (*pro re nata*) psychotropic medication during an inpatient stay within a mental health ward is a frequently used practice and an often valuable strategy for managing individuals with fluctuating mental state where nursing staff can administer medication at their discretion.

Local and national audit work however, has identified areas for improvement in the way that *as required* psychotropic medications are prescribed, administered, documented and reviewed.[2,3,4]

For individuals who are detained under the Mental Health (Care and Treatment (Scotland) Act 2003, careful consideration must be given prior to prescribing and administering any *as required* psychotropic medication to ensure that its use is authorised under the Act (i.e. where the patient has a T2 or T3 certificate, it specifies the intervention).

Any emergency treatment under the 2003 Act should be recorded on form T4. This will include treatment that is urgently necessary but is not covered by an existing T2 or T3 certificate. The T4 form should be used to notify the Mental Welfare Commission (MWC) of the administration of urgent treatment retrospectively.

For further advice, see the MWC's Advice Notes on Medical Treatment under Part 16 and Consent to Treatment Good Practice Guide.[5,6]

1.	Prescribing
1.1	All prescriptions for *as required* psychotropic medication should be tailored to the individual patient.
1.2	The choice of *as required* psychotropic should be guided by the patient's presentation, their concurrent regular medication, previous response to treatment and any co-morbid physical health issues.
1.3	Any advance statement that addresses medication use should be taken into consideration prior to prescribing *as required* psychotropic medication.
1.4	*As required* psychotropic medications should not, as a rule, be prescribed routinely on admission. However, in areas with limited prescribing support, it may be appropriate to prescribe *as required* psychotropic medication on admission, if following assessment, this is deemed appropriate.
1.5	Prescriptions for *as required* psychotropic medications must state the following;[7] • dose • route of administration • minimum dose interval • maximum dose that can be administered in 24 hours • clear indication for administration i.e. what symptoms are being targeted by the intervention
1.6	Consider the pharmacokinetic properties of *as required* psychotropic medication prior to prescribing. **(*Table 1: Pharmacokinetics of oral psychotropic medication)***
1.7	Consider if the medication is prescribed via two routes (e.g. both oral and IM) and state the maximum cumulative dose.
1.8	High dose antipsychotic therapy (HDAT) may sometimes be used in an emergency for acute symptoms. This can happen, particularly, with the use of *as required* antipsychotics. Consider the patient's regular prescribed medication. Prescribers should be aware when prescribing *as required* medications, of inadvertently causing the potential for HDAT. This should be discussed with the consultant psychiatrist before this happens. High dose antipsychotic treatment guidelines[8]
1.9	When prescribing *as required* benzodiazepines, consider any existing prescription for a regular benzodiazepine in the context of tolerance and potential ineffectiveness. The sedative antihistamine, promethazine may be a useful alternative in these circumstances.
1.10	Benzodiazepines should be first line in antipsychotic-naïve patients, where there is a history of epilepsy or if there is a chance behaviour is related to seizure activity.
1.11	*As required* antipsychotics should not routinely be prescribed for antipsychotic-naïve patients.
1.12	The patient's regular antipsychotic ***may*** be an appropriate choice for *as required* use (e.g. olanzapine, quetiapine, risperidone). Clozapine would be an exception to this advice and **must not** be used on an as required basis.

1.	Prescribing
1.13	If haloperidol is prescribed *as required*, consider the patient's other prescribed medication and potentially contraindicated combinations. Where practical, an ECG should be undertaken prior to prescribing (see below).
1.14	An entry in the patient's clinical notes should be made detailing the reason for the prescription and providing further context for the indication.
1.15	At the earliest opportunity (usually at the first multidisciplinary team meeting), an individualised treatment plan should be developed to include suitable de-escalation techniques, oral *as required* psychotropic medications and where appropriate, IM psychotropic medications. For further information on use of IM medication refer to; NHSL Guideline for IM medication for Acute Behavioural Disturbance[8]

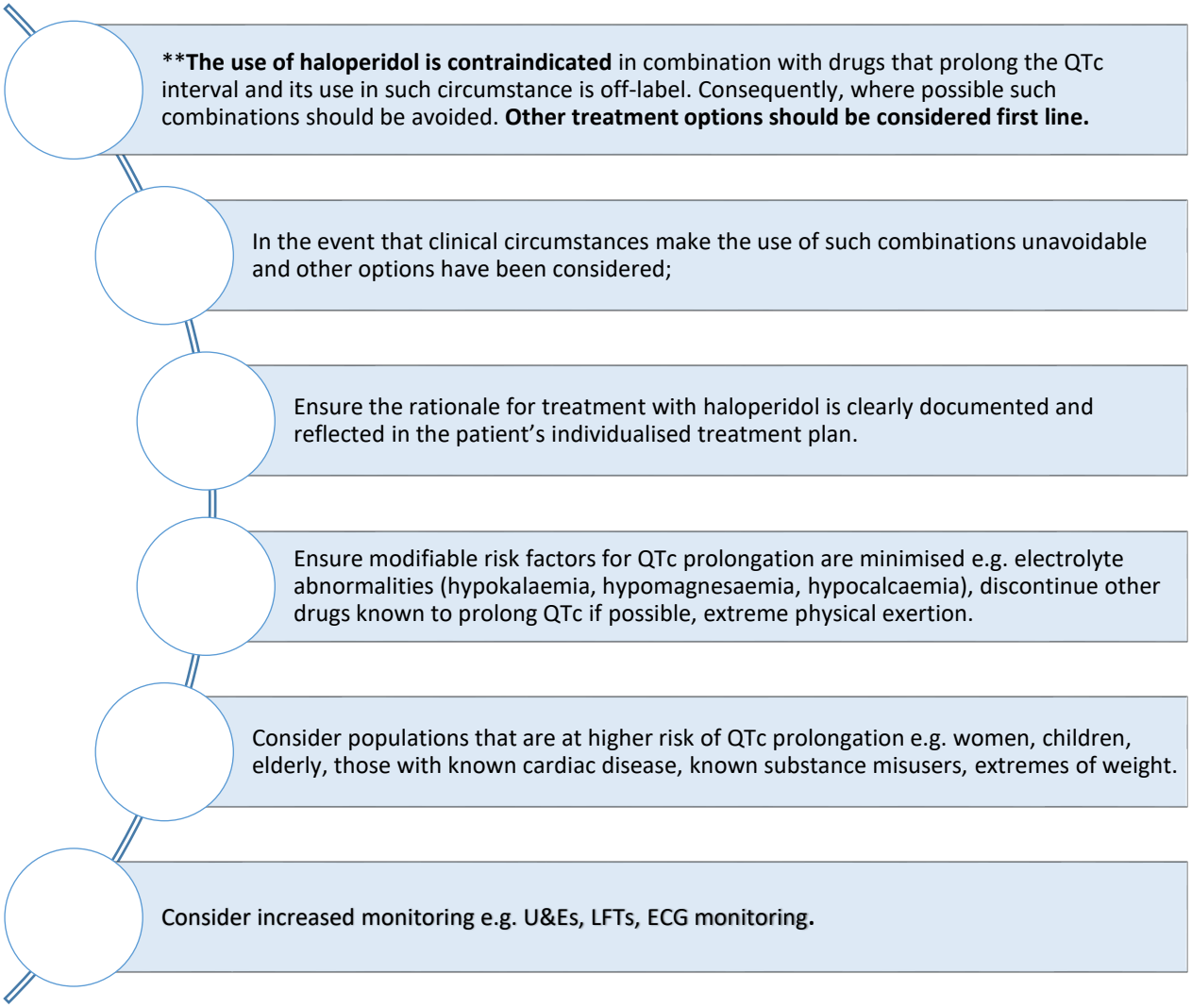

Table 1: Pharmacokinetics of oral psychotropic medication [9,10]				
Medication	Usual adult doses [a]	Max adult dose/ 24 hours [b]	Time to peak concentration (Tmax)	Elimination half-life ($t_{1/2}$)
Lorazepam	0.5-1mg	4mg	2 hours	10-20 hours
Diazepam	2-5mg	30mg	30-90 mins	24-48 hours [c]
Promethazine	25-50mg	100mg	2-3 hours	5-14 hours
Chlorpromazine [d]	25-50mg	1000mg	2-4 hours	30 hours
Haloperidol [e]	1.5-5mg	20mg [f]	2-6 hours	12-38 hours
Olanzapine	5mg	20mg	5-8 hours	30-38 hours
Quetiapine	25-50mg	750mg	1.5 hours	6-7 hours
Risperidone	500micrograms -1 mg	16mg [g]	1-2 hours	19.5 hours

Footnotes

a. lower doses of medication should be used in older adults, those with co-morbid conditions, individuals of low body weight, patients under 18 years of age and adults with a learning disability (unless it has been established that standard doses are necessary and it is in accordance with the patient's individualised treatment plan)

b. consider regular medication and the potential for exceeding the BNF maximum dose recommendations with the use of *as required* medication, especially in relation to antipsychotic prescribing and the potential for inadvertent high dose

c. active metabolite of diazepam has a half-life of 2-5 days

d. chlorpromazine is a potent antihistamine and sedative, but has a wide ranging effect on other receptors and can be poorly tolerated. In practical terms, its use should be reserved for a minority of patients who have a prior history of its use.

e. do not use haloperidol in the following situations;
- In Lewy body dementia or where it cannot be excluded
- In older adults (unless under specialist advice)
- In frail adults (unless under specialist advice)
- In learning disability (unless under specialist advice)
- In patients under 18 years of age
- If the patient is antipsychotic naïve
- If the cardiac status is unknown (need baseline ECG prior to haloperidol)
- If there is evidence of cardiovascular disease including prolonged QTc
- In combination with other drugs that can prolong the QTc interval

Refer to delirium guidance for the use of haloperidol in treatment of delirium[1]

f. in practice the dose of haloperidol should only exceed 15mg/24 hours in exceptional circumstances

g. usual adult maximum dose of risperidone does not exceed 6mg/ 24 hours

2. Administration

2.1 *As required* psychotropic medications should only be administered for the prescribed indication and only where non-pharmacological approaches have failed or are inappropriate.

2.2 Where a patient is prescribed more than one *as required* psychotropic medication for the same indication, avoid administering combinations where possible and allow sufficient time to ascertain effect of first drug before administering another. **(*Table 1: Pharmacokinetics of oral psychotropic medication)***

2.3 Ensure there is sufficient monitoring in place for potential adverse effects associated with the use of prescribed *as required* psychotropic medication.

2.4 Where *as required* oral psychotropic medication is used for management of acute behavioural disturbance, consideration must be given to monitoring physical observations using NEWS. (BAP recommends physical monitoring using the NEWS tool every hour for a minimum of one hour after the administration of oral psychotropic medication.[11])

3. Documentation

3.1 All administration of *as required* psychotropic medication must be recorded on the prescribing and administration system (either on HEPMA or paper inpatient prescription).

3.2 All administration of *as required* psychotropic medication should be documented within the patient's clinical notes. Best practice would suggest that the following are considered and documented;

- Date and time of administration
- Medication and dose administered
- Reason for administration
- Details of any non-pharmacological approaches attempted prior to medication administration
- Details of the response to the intervention
- Details of any adverse effects noted
- Details of physical health monitoring undertaken where appropriate

4.	Review
4.1	There should be a regular review (at least weekly) of *as required* psychotropic medication as part of the multidisciplinary team meeting and evidence of this review should be documented in the clinical notes by the prescriber. Ongoing use of *as required* psychotropic medication without review potentially increases the risk of adverse effects e.g. falls risk in elderly, dependence and tolerance (with benzodiazepines).
4.2	Where there is ongoing use of *as required* psychotropic medication, there should be a review and consideration to optimisation of regular medication.
4.3	The ongoing need for *as required* psychotropic medication should be reviewed frequently. If *as required* medication has not been administered for 2 weeks, consider discontinuing, unless otherwise clinically indicated.
4.4	*As required* psychotropic medications should not be routinely prescribed for passes from hospital or on discharge.

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