PRESCRIBING GUIDANCE FOR MANAGING ADULTS WITH LEARNING DISABILITY WHO DISPLAY/S BEHAVIOURS THAT CHALLENGE
SEPTEMBER 2018
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Approved by (Group): Drugs and Therapeutics Committee

Approved by (Committee): Quality Committee

Insert date

Document history

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<tr>
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Membership of the policy development/review team

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Further copies of this document can be found on the Foundation Trust intranet.
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1 Introduction

1.1 This guidance has been produced to provide advice to prescribers, who may consider prescribing medication to manage adults with a learning disability who display/s behaviour that challenges. It is based on The Frith Prescribing Guidelines for adults with intellectual Disability (1) and the learning disability medication guidance from Birmingham University: Using medication to manage behaviour problems among adults with a learning disability (2), NICE guidance NG11, published May 2015 (3) and The STOMP Campaign supported by NHS England.

2 Aims and objectives

2.1 To provide safe and effective advice on the prescribing of psychotropic medication to manage behaviour that challenges in the absence of psychiatric disorder, when non-medication management strategies have failed.

3 Scope of the policy

3.1 This policy relates to prescribing in adults with a diagnosed learning disability under the treatment of C&I.

4 General Principles Underlying the Prescribing of Medicines for Behaviour that Challenges

4.1 Aggressive challenging behaviour is common in learning disability, 16-50% exhibit aggression or a related challenging behaviour (4).

4.2 Behaviour problems or behaviour that challenges may present as verbal aggression, physical aggression to self, others or property (2).

4.3 There may be many reasons for behavioural problems, including physical or mental health problems, contributing factors could be negative childhood experiences, maladaptive coping strategies, and environmental factors such as an under stimulating or over stimulating environment (2).

4.4 Behaviour that challenges may sometimes be seen as a form of communication in people with learning disability which they may present when they are seeking to express confusion, distress or pain.

4.5 Consider antipsychotic medication to manage behaviour that challenges only if:
   - Psychological or other interventions alone do not produce change within an agreed time or
   - Treatment for any coexisting mental or physical health problem has not lead to a reduction in the behaviour or
   - The risk to the person or others is very severe (for example because of violence, aggression or self-injury).
4.6 Antipsychotic medication should only be offered in combination with psychological or other interventions.

4.7 The use of psychotropic medication is off-label for the management of behaviour disorders in people with learning disability, and hence the C&I policy for unlicensed medicines and unlicensed use of licensed medicines (off-label) must be followed when prescribing any medicine outside their current product license (off-label) \(^5\).

4.8 The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The person offered the medication (or those with authority to give consent on their behalf) should provide informed consent, which should be documented.

4.9 Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

5 Assessment and Formulation

5.1 Managing behaviours should take place in a person centred way.

5.2 Physical causes of any aggressive behaviour should be investigated where possible. A sudden onset would indicate an MRI or CT scan of the head. Other investigations could include a urine test to eliminate urinary tract infection, blood glucose test and thyroid function test. If medication is planned to be prescribed, a full blood count, liver and renal function tests and urea and electrolytes analysis should be performed.

5.3 Where possible, a Positive Behaviour Support approach for managing the behaviour should be adopted including undertaking a functional assessment to understand the cause of the behaviour and its consequences prior to beginning treatment with medication.

5.4 Assessment and formulation should usually include input from the multi-disciplinary team members, family and carers.

5.5 For a detailed account of assessments and formulation, the following documents should be consulted:

- British Psychological Society (BPS) guidelines on the management of challenging behaviour.
- The joint statement produced by the BPS and the learning disability faculty of the Royal College of Psychiatrist (RCPsych) titled ‘Challenging behaviour: a unified approach’ (2007). (http://www.rcpsych.ac.uk/files/pdfversion/cr144.pdf)
6 Good Prescribing Principles

6.1 As far as possible, one medication should be prescribed at a time.

6.2 As a general rule, the medication should be used within the BNF recommended range of doses.

6.3 Consideration for withdrawing medication and exploring non-medication management options should be ongoing.

6.4 There are a lack of studies of combinations of psychotropic medication to manage behaviour problems among adults with a learning disability.

6.5 If an add-on medication is indicated:
   - The rationale for using an add-on medication must be recorded.
   - The effectiveness and adverse effects should be monitored in the same way as the first medication. See Section 9.
   - If the add-on medication is ineffective, reassess the situation.
   - Try to return to monotherapy as soon as possible.

7 Medication

7.1 Optimise existing medication (in line with the NICE guideline on Medicines Optimisation, NG5) for coexisting mental or physical health problems identified as a factor in the development and maintenance of the behaviour that challenges.

7.2 Consider antipsychotic medication to manage behaviour that challenges only if:
   - psychological or other interventions alone do not produce change within an agreed time or
   - treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour or
   - the risk to the person or others is very severe (for example, because of violence, aggression or self-injury).

7.3 When choosing which antipsychotic medication to offer, take into account the person's preference (or that of their family member or carer, if appropriate), side effects, response to previous antipsychotic medication and interactions with other medication. See C&I Antipsychotic Prescribing Guidelines and C&I Medicines Formulary.

7.4 When prescribing an antipsychotic, the learning disabilities psychiatrist should:
   - Identify the target behaviour.
   - Decide on a measure to monitor effectiveness (for example, direct observations, the Aberrant Behavior Checklist or the Adaptive Behavior Scale), including frequency and severity of the behaviour and impact on functioning.
   - Commence treatment with a trial of ‘prn’ antipsychotic.
   - Start with a low dose and use the minimum effective dose needed.
   - Only prescribe a single medicine.
• Monitor side effects as recommended in the C&I Antipsychotic Prescribing Guidelines.
• Review the effectiveness and any side effects of the ‘prn’ medication after 1-2 weeks.
• Stop the medication if there is no indication of a response after 2 weeks, reassess the behaviour that challenges and consider further psychological or environmental interventions.
• Consider prescribing a regular antipsychotic if there is a response to the ‘prn’ antipsychotic and if there are regular, frequent episodes of the behaviours that challenge. See section 7.2.
• Review the medication if there are changes to the person’s environment (for example significant staff changes or moving to a new care setting) or their physical or mental health.
• If the antipsychotic is not tolerated, consider switching treatment to another antipsychotic taking into account its side effect profile. See section 7.7.
• Conduct a full multidisciplinary review after 3 months and then at least every 6 months covering all prescribed medication (including effectiveness, side effects and plans for stopping).
• Only continue to prescribe medication that has proven benefit.

7.5 Ensure that the following are documented:
• A rationale for medication (explained to the person with a learning disability and everyone involved in their care, including their family members and carers) including if the medication is off-label or an unlicensed indication.
• How long the medication should be taken for.
• A strategy for reviewing the prescription and stopping the medication.
• If there is a positive response to antipsychotic medication record the extent of the response, how the behaviour has changed and any side effects or adverse events.

7.6 When prescribing is transferred to primary or community care, or between services, the specialist must give clear guidance to the practitioner responsible for continued prescribing about:
• Indication for the medication.
• Which behaviours to target.
• Monitoring of beneficial effects and side effects.
• Taking the lowest effective dose.
• Dosing interval and maximum daily dose.
• How long the medication should be taken for.
• Plans for stopping the medication.

7.7 In instances where the behaviour that challenges partially improves or does not improve the prescriber should review the initial formulation and rationale for using the medication.
• Check that the medication is used at an adequate dosage and for an adequate duration.
• Check for tolerability and adverse effects.
• Check compliance.
• Assess the impact of other interventions.
• Consider whether there is a need to increase the dose of the existing medication to the clinically effective maximum dose without causing adverse effects.
• Assess whether the medication is still indicated.
• Consider planned withdrawal if the medication is no longer indicated.

7.8 In instances where the behaviour that challenges deteriorates during treatment:
• The prescriber should assess the possible reasons for deterioration in the behaviour, including adverse effects of the medication.
• If the deterioration is caused by the medication, the prescriber should withdraw the medication as detailed below.

7.9 In instances where the behaviour that challenges re-emerges after reducing the dose or withdrawing the medication:
• The prescriber should be aware of the discontinuation symptoms of certain medication and allow adequate time for the behaviour to settle before reconsidering the use of medication.
• Discontinuation symptoms of antipsychotics include headache, nausea and insomnia.
• The prescriber should consider non-medication based interventions and reassess the initial formulation and rationale for using medication.
• The prescriber may consider when required (PRN) medication before re-instituting regular medication.

7.10 Antipsychotics

Risperidone is not licensed in adults over 18 for the short term treatment of persistent aggression in conduct disorders. However, based on the evidence in children, risperidone should be prescribed first line in adults for this indication.

7.10.1 Risperidone is licensed for short term treatment (of up to 6 weeks) of persistent aggression in conduct disorder in children and adolescents (5-18 years) under specialist supervision, with sub average intellectual functioning or mental retardation diagnosed according to DSM-IV criteria, in whom the severity of aggressive or other disruptive behaviours require pharmacological treatment (6). It may be effective in reducing severe irritability and aggression in children or young people with autistic disorder and learning disability (7,8).

7.10.2 Open label and retrospective (9) trials have shown risperidone and olanzapine to be effective in managing behavioural problems. However, the position of risperidone in the treatment of children with aggression and disruptive behaviour is robust as there are several randomized trials with risperidone.

7.10.3 Risperidone is not licensed in adults over 18 for the short term treatment of persistent aggression in conduct disorders. However,
based on the evidence in children, risperidone should be prescribed first line in adults for this indication.

7.10.4 Risperidone should be initiated on a low dose, 0.5mg once a day and increased up to 3mg with a maximum dose of up to 6mg by consultant, with regular assessments during titration for effect as well as the emergence of side effects.

7.10.5 A Cochrane review (10) published in 2016; Aripiprazole for Autism Spectrum Disorders reviewed 3 trials. It was concluded that 2 RCTs suggest aripiprazole can be effective as short term intervention for some behavioural aspects of autism spectrum disorder (ASD) in children and adolescents (less irritability, hyperactivity and fewer stereotypies however side effects notable. 1 long term placebo discontinuation study suggests that re-evaluation of aripiprazole after a period of stability is warranted.

7.10.6 Aripiprazole is not licensed for the treatment of behaviour that challenges however there is some evidence to suggest that it may be effective as a short term intervention for some behavioural aspects of ASD in children. Aripiprazole can be prescribed 2nd line in adults with a learning disability for behaviour that challenges.

7.10.7 If behaviour is due to a psychotic illness, then a trial of antipsychotic medication should be considered. Refer to the C&I Trust Antipsychotic Prescribing Guidelines (11).

7.11. Benzodiazepines

7.11.1. There is little or no indication for the use of benzodiazepines for the treatment of behavioural and emotional disturbance (12).

7.11.2. Lorazepam and diazepam are licensed for short term use in managing anxiety.

7.11.3. Lorazepam, clonazepam (unlicensed use) and diazepam may be used short term when a calming or sedative effect is appropriate and in the management of behaviour disorder, arising through arousal and hyperactivity.

7.11.4. Benzodiazepines should be used with caution as they may cause disinhibition and irritability in individuals with organic brain impairments.
7.12 When Required ‘PRN’ Medication

7.12.1 In line with the 2015 NICE guidance on behaviours that challenge, PRN, alongside other regular psychotropic medication use, is strictly to be seen as a second line treatment behind Positive Behavioural Support.

7.12.2 The over-use of PRN medication may represent chemical restraint and thus be seen as a safeguarding issue.

7.12.3 In the community teams, LD psychiatrists may make recommendations to the GP for initiating such prescriptions. However, at times, PRN medication may be prescribed by LD psychiatrists using LD FP10s.

7.12.4 Where PRN medication has been prescribed by LD psychiatrists, directions of use must be clearly communicated in writing to the GP and carers according to section 7.6. Easy read information should be added for the benefit of the patient.

7.12.5 Clear PRN guidelines for administration should be available to the staff/carers, as per Appendix 1 and Appendix 2.

7.12.6 The PRN guidelines must include both the indicators for use of PRN medication and the steps that should always be taken prior to PRN use (e.g. behavioural guidance, distraction, re-direction etc.), and clearly state that PRN is only to be used if the preceding steps have failed to calm the patient.

7.12.7 The guidance must also state the recording and reporting expectations placed on the administrator of the ‘prn’ medication (e.g. each use must be recorded on a MAR chart and be presented to the prescriber at review).

7.12.8 The PRN guidelines should also clearly state the amount of PRN medication administration over any weekly / monthly period that will trigger a review of its use.

7.12.9 If the situation is urgent, the client’s needs must take precedence. Records must be completed as soon as possible.

7.12.10 The prescriber should clearly record the reason, duration and review plans on relevant IT systems

7.12.11 Duration of recommended prescription:

- In acute, first use cases, the prescription should not be for more than 2 weeks
- In complex cases with a longer history and significant behaviours that challenge, it may be necessary to have provision for longer period.
- This must be regularly reviewed.
- Emphasis must be on the implementation of a Positive Behavioural Support Plan.
- Any longer than expected use or over use of such medication should be considered within the MDT.

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- This must be regularly reviewed.
- Emphasis must be on the implementation of a Positive Behavioural Support Plan.
- Any longer than expected use or over use of such medication should be considered within the MDT.
7.13 Interventions for Sleep Problems NICE NG 11

7.13.1 Behavioural interventions for sleep problems in adults with a learning disability who display/s behaviour that challenges should consist of a functional analysis of the problem sleep behaviour and a structured bed time routine.

7.13.2 LD psychiatrists can consider prescribing melatonin as second line treatment particularly in individuals with autism or dementia, to aid sleep if the sleep problem persists after a behavioural intervention.

7.13.3 Melatonin is off-label for the treatment of sleep interventions in adults with learning disability.

7.13.4 Review this medication regularly to evaluate continuing need and ensure that the benefits outweigh the risks.

8 Adverse effects

8.1 Atypical antipsychotics carry a certain amount of risk associated with adverse effects relating to weight gain, cardiac abnormalities and various metabolic abnormalities, including impaired glucose tolerance.

8.2 There is no good quality evidence to either support or refute concerns that people with learning disability may be at greater risk of the adverse effects of medication than people from the general population.

8.3 However, people with learning difficulties often have additional problems or disabilities which make them more likely to experience side effects. For example antipsychotic and antidepressant medications vary in their propensity to lower the convulsive threshold or to cause movement abnormalities, so the potential benefits and risks of the treatment should be considered carefully (12,13).

8.4 It is recommended that advice about serious and important adverse events should be made available to the person and their carer at the time of prescribing or as soon as possible.

8.5 Information leaflets about adverse effects should be made available. Easy read medicine information leaflets can be accessed via the following link (http://www.ld-medication.bham.ac.uk), via The Elfrida Society (http://www.elfrida.com) and via the Choice and Medication links on the C&I website (http://www.choiceandmedication.org/candi/)

9 Monitoring of treatment

9.1 Side effects of antipsychotic medication should be reviewed at least once a year. The review should include assessment for the presence of extrapyramidal side effects and screening for the four aspects of metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia (NICE schizophrenia guideline update CG82, 2009). Appendix 2.
9.2. The Lester UK Adaptation: Positive Cardiometabolic Health Resource supports the recommendations relating to monitoring physical health in the NICE guidelines on Psychosis and Schizophrenia in Adults (cg178) and Young People (cg155). www.rcpsych.ac.uk/quality/NAS/resources.

9.3 Treatment effects should be monitored effectively by using standardised rating scales. See section 7.4.

9.4 All adverse effects should be assessed using an appropriate rating scale and should be recorded clearly. Appendix 4.

9.5 The patient’s capacity should be re-assessed at each review.

9.6 At each follow up, reduction or withdrawal of medication should be considered.

9.7 The following link is to a leaflet prepared by Voluntary Organisations Disability Group (VODG) for family and support workers to use when preparing to visit a doctor to talk about psychotropic medication. https://www.vodg.org.uk/wp-content/uploads/2017-VODG-Preparing-to-visit-a-doctor-to-talk-about-psychotropic-medicine.pdf

10 Discontinuation of treatment plan

10.1 Once a medication is prescribed, the prescriber should continue to evaluate the risk–benefit profile regularly, with particular emphasis on the individual and their family or carer’s quality of life.

10.2 In instances where the behaviour that challenges improves, the prescriber should consider careful reduction and withdrawal of medication. The rate and timing of withdrawal should be based on the patient and the purpose of the medication. Withdrawal of long term treatments should be considered within 6-12 months.

10.3 The rate of withdrawal may depend on the type of the medication used, the severity of the behaviour, the non-medication management options and previous response to withdrawal.

10.4 The decision to withdraw medication should only be made after discussion with the patient and or the family or carers. Withdrawal of medication should be undertaken in a planned and systematic manner, with careful monitoring of effects on behaviour.

11 Dissemination and implementation arrangements

The policy will be made available on the trust intranet and circulated to all relevant prescribers.

12 Training requirements

For training requirements please refer to the Trust’s Mandatory Training Policy and Learning and Development Guide.
13 Monitoring and audit arrangements

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<th>Elements to be monitored</th>
<th>Lead</th>
<th>How trust will monitor compliance</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
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<tbody>
<tr>
<td>Treatment review and monitoring of side effects</td>
<td>Consultant / Chief Pharmacist</td>
<td>Audit</td>
<td>Annual</td>
<td>DTC</td>
<td>Required actions will be identified and completed in a specified timeframe</td>
<td>Required changes to practice will be identified and actioned within a specific timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

14 Review of the policy

3 years

15 References

3. NICE guidance ng11, published May 2015
5. C&I policy Unlicensed medicines and unlicensed use of licensed medicine (off label) 2014: Unlicensed medicines and unlicensed use of licensed medicine (off label)


16. C&I Medicines Formulary Medicines formulary

16. Associated documents

16.1 C&I Rapid tranquillisation guideline should be followed for the management of imminent violence in a psychiatric setting for adults with learning disability (14).

16.2 When required (PRN) prescribing of ‘as and when required’ medication should be part of the overall treatment care plan and when possible should be prescribed after discussing with the patient and or their family and carers (11). Please refer to the C&I guideline on prescribing PRN psychotropics (11)

16.3 Prescribing of high dose medication (doses above the BNF recommended maximum) should only be used in exceptional circumstances (2). The evidence base for the effectiveness of high dose medication should be explored and if available should be documented. Please refer to the C&I guideline on high dose antipsychotic prescribing (15).
Appendix 1
Guidelines for Administration of PRN (As required medication)

Patient’s Name:

Date of Birth:

Medication, strength and form (E.g. lorazepam 1mg tablet):

Directions (E.g. One tablet to be taken orally):

Maximum dose in 24hours:

Signs that (patient’s name) may need this medication (E.g. unable to respond to staff’s’ efforts to reassure, physical aggression):

1.
2.
3.

If (patient’s name) is displaying any of those signs, then the following must be attempted before the use of the PRN medication: -

1. E.g. Distraction…
2. E.g. Relaxation…
3. E.g. Re-direction…

The medication must only be administered if those steps have failed to calm (patient’s name)

After (patient’s name) has taken the medication:

1. Document clearly on Medication Administration Record Sheet MARS (date, time, dose) and other relevant recording sheets
3. Monitor any signs of improvement or worsening.
4. Document circumstances (e.g. on ABC chart, incident report) as relevant.
5. Forward the recording charts to the relevant CLDS or ILDP professional and / or the prescriber.

If (patient’s name) does not take medication:

2. Re-consider offering this prn medication after (insert time), if staff/carers continue to have concerns.
Appendix 2
Positive Behaviour Support PRN Guidelines Template

Guidelines for Administration of xxxx mg (As required medication)  Prescribed for xxxxxx  Date:

Medication, strength and form:

Directions:

Maximum dose in 24hours:

Dosage Interval:

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>GREEN</td>
<td>This is the phase where xxxx is calm and relaxed. xxxx is NOT required in this stage.</td>
</tr>
<tr>
<td>AMBER</td>
<td>This is the phase where xxxx is starting to feel anxious and distressed. Take quick action and use the Secondary Preventative Strategies to help to prevent xxxx’s behaviour from escalating. Continue to use all de-escalation strategies</td>
</tr>
<tr>
<td>RED</td>
<td>This is the phase where xxxx is displaying behaviour that challenges. You need to do something quickly to achieve safe and rapid control over the situation and to prevent unnecessary distress or injury to yourself, others or xxxx. Continue to use de-escalation, diversion and distraction strategies throughout. If these measures are unsuccessful: Offer xxxx</td>
</tr>
<tr>
<td>BLUE</td>
<td>This is the phase where xxxx is calming after being in the RED reactive phase.</td>
</tr>
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</table>

Proactive management of behaviour is used to avoid unnecessary use of prn meds

After xxxx has taken xxxx:

1. Document clearly on Medication Administration Record Sheet - MARS (date, time, dose) and other relevant recording sheets
2. Be aware that xxxx can take xxxx minutes to start working
3. Continue to support xxxx by using their Positive Behavioural Support Plan
4. Monitor the effects of xxxx. Common side effects include xxxx. A full list of side effects can be found on the patient information leaflet accompanying the medicine.
5. Use ABC chart to document the incident
Date

Private & Confidential

GP Address

Dear Doctor,

Re: patient , DoB: , Address , NHS number

The Islington Learning Disability Partnership has been taking part in the National Prescribing Observatory Mental Health-UK audit.

As you will be aware while prescribing antipsychotic medication regular monitoring of metabolic and extrapyramidal side-effects is required (per NICE guidelines and Quality and Outcome framework for long-term antipsychotic prescribing).

We would be grateful if you could send us the following update of information regarding the above patient:

<table>
<thead>
<tr>
<th>Mandatory Tests</th>
<th>Date</th>
<th>Result</th>
<th>Action (If required)</th>
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<td></td>
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<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Blood Lipid profile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Indicated Tests</th>
<th>Date</th>
<th>Result</th>
<th>Action (If required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other relevant blood tests</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your cooperation.

Yours sincerely,

Dr. ...........
# Appendix 4

**GLASGOW ANTIPSYCHOTIC SIDE – EFFECT SCALE (GASS)**

**NAME:** ..........................................................  **AGE:** ............  **SEX:** M / F

<table>
<thead>
<tr>
<th>OVER THE PAST WEEK</th>
<th>Never</th>
<th>Once</th>
<th>A few times</th>
<th>Everyday</th>
<th>Tick this box if distressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt sleepy during the day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I felt drugged or like a zombie</td>
<td></td>
<td></td>
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<tr>
<td>3. I felt dizzy when I stood up or have fainted</td>
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<tr>
<td>4. I have felt my heart beating irregularly or unusually fast</td>
<td></td>
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</tr>
<tr>
<td>5. My muscles have been tense or jerking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. My hands or arms have been shaky</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. My legs have felt restless /or I couldn’t sit still</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. I have been drooling</td>
<td></td>
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<tr>
<td>9. My movements or walking have been slower than usual</td>
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<tr>
<td>10. I have had, or people have noticed uncontrollable movements of my face and body</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. My vision has been blurry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. My mouth has been dry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I have had difficulty passing urine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I have felt like I am going to be sick or have vomited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I have wet the bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I have been very thirsty and/or passing urine frequently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The areas around my nipple have been sore or swollen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I have noticed fluid coming from my nipples</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I have had problems enjoying sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Men only: I have had problems getting an erection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tick yes or no for the following questions about the last three months

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Tick this box if distressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Women only: I have noticed a change in my periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Men and women: I have been gaining weight</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GLASGOW ANTIPSYCHOTIC SIDE – EFFECT SCALE (GASS)

Scoring Guide

On the questionnaire questions 1 – 20 relate to how the service user has felt over the previous week and questions 21 and 22 relate to how the service user has felt in the last 3 months

For questions 1 – 20

<table>
<thead>
<tr>
<th>Answers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0 points</td>
</tr>
<tr>
<td>Once</td>
<td>1 points</td>
</tr>
<tr>
<td>A few times</td>
<td>2 points</td>
</tr>
<tr>
<td>Everyday</td>
<td>3 points</td>
</tr>
</tbody>
</table>

For questions 1 – 20

<table>
<thead>
<tr>
<th>Answers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3 points</td>
</tr>
<tr>
<td>No</td>
<td>0 points</td>
</tr>
</tbody>
</table>

Add together the points for all of the questions to get an overall total and compare with the table below

<table>
<thead>
<tr>
<th>Overall total</th>
<th>Side effects rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 12</td>
<td>Absent/mild side effects</td>
</tr>
<tr>
<td>13 - 26</td>
<td>Moderate side effects</td>
</tr>
<tr>
<td>Over 26</td>
<td>Severe side effects</td>
</tr>
<tr>
<td>Equality Impact Assessment Tool</td>
<td>Yes/No</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
</tr>
<tr>
<td>3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>5. If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6. What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7. Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>