Livewell Southwest

Depot Antipsychotic Medication (including risperidone long acting injection)

Policy and Practice Guidelines
For use in adults

Version No 4.3
Review: August 2017

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Chief Pharmacist**

Asset Number: **16**

Reader Information

Title	Depot Antipsychotic Medication (including risperidone long acting injection). Policy and Practice Guidelines for use in adults. V.4.3
Asset number	16
Rights of access	Public
Type of paper	Clinical Policy
Category	Clinical (Mental Health and Learning Disabilities Directorate)
Subject	The use of Long Acting Neuroleptic medication
Document Purpose and Description	To provide guidance to clinical staff on the administration of Depot Antipsychotic Medication (including risperidone long acting injection), and to provide guidance and support for the ongoing care and monitoring of service users receiving these treatments
Author	Chief Pharmacist / Mental Health Pharmacists
Ratification date and group	Provider Medicines Governance Group 01/02/13
Publication date	2nd February 2017
Review date and frequency of review	August 2018
Disposal date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Chief Pharmacist
Target audience	All Clinical staff
Circulation list	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☎ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	Consultation with: Mental Health Prescribers Mental Health ward / unit managers / clinical leads Non Medical Prescribers Provider Medicines Governance Group Locality Managers / Deputies Medicines Management Team, NHS Plymouth
Equality analysis checklist completed	Yes
References/Source	1. National Institute for Health & Clinical Excellence – Core Interventions in the treatment and management of schizophrenia in adults in Primary and Secondary Care, Clinical guideline 82, March 2009 2. British National Formulary (BNF) 64 (Sep 2012) 3. Royal College of Psychiatrists: Consensus Statement on high-dose antipsychotic medication. Council report CR138 May 2006. 4. Plymouth Area Joint Formulary, Chapter 4: **http://www.plymouthformulary.nhs.uk/4-Central-**

	Nervous-System/ accessed on 1/11/12 5. Taylor, D; Paton, C; Kapur, S: Maudsley Prescribing Guidelines in Psychiatry 11th edition 2012-11-02 6. Bazire, S: Psychotropic Drug Directory 2010 7. College of Mental Health Pharmacists (formerly UKPPG): Guidance on the Administration of Oil based Depot and other Long Acting Intramuscular Injections, 2009 8. SPC for Risperdal Consta® http://www.medicines.org.uk/emc/ accessed on 1/11/12 9. Liverpool University Neuroleptic Side Effect Rating Scale (Lunsers): http://www.mirecc.va.gov/visn22/LUNERS.doc Appendix E references:- 10. Cocoman A, Murray J (2006) IM injections: How's your technique? WIN April 11. Greenaway K. (2004) Using the Ventro-Gluteal site for intramuscular injection. Nursing Standard 18 (29) 39-42. 12. Malkin, B. (2008) Are techniques used for intramuscular injection based on research evidence? *Nursing Times*; 104: 50/51, 48–51. 13. Marsden Manual of Clinical Nursing Procedures, Fifth Edition (2000) Eds: J. Mallett & L Dougherty. Chapter 12, Drug Administration. 223 - 224 14. Plotkin, S. et al (2008) *Vaccines (5th ed)* Saunders Elsevier. 15. Rodger M A & King L. (2000) Drawing up and administering intramuscular injections: a review of literature. Journal of Advanced Nursing. 31 (3): 574-582 16. Workman B. (1999) Safe injection techniques. Nursing Standard 13 (39), 47-52.
Supersedes Document	v.4.1
Author Contact Details	**By post:** **Local Care Centre Mount Gould Hospital** 200 Mount Gould Road Plymouth Devon PL4 7PY **Tel:** **0845 155 8085** **Fax:** **01752 272522 (LCC Reception)**

Document Review History

Version No.	Type of Change	Date	Originator of Change	Description of Change
For previous review history please contact the PRG secretary.				
2.6	Revised	January 09	Practice Facilitator and Mental Health Pharmacist	
2.7	Minor amendments/ formatting changes	April 2009	Practice Facilitator MH & LD/ Policy ratification group secretary	Formatting/updating/clarifying.
2.8	Revision	April 2010	Training and Development Manager - Mental Health Partnership Delivering Race Equality Mental Health – Lead	New appendix E.
2.9	Updates	June 2010	PMGG	Updates.
3	Ratified	June 2010	Policy Ratification Group	Ratified.
3.1	Amendment	July 2011	Author	Amendment to author details
3.2	Reviewed	April 2012	Author	Review date extended, no other changes made.
3.3	Review	Oct 2012	Author	Reformatted and thorough review
4.0	For ratification	Dec 2012	Author	For approval by PMGG following consultation
4.1	Updated	Jun 2016	A Hawke	Updated and formatted.
4.2	Extended	July 2016	Chief Pharmacist	Extended.
4.3	Extended	February 2017	Clinical Director of Pharmacy	Extended.

Depot Antipsychotic Medication (including risperidone long acting injection). Policy and Practice Guidelines for use in adults

1. Introduction

1.1. Depot medication is part of a range of treatment and long-term care available for adults with severe mental illness.

1.2 Research has shown that depot medications work best in combination with attentive aftercare from health and social services, with regular reviews of dosage; administration and the effects of the total package of care.

1.3 Anti-psychotic drugs are considered an indispensable treatment option for most people in the recovery phase of a psychotic illness.

1.4 It will be our aim to assist service users to make an informed choice as to the anti-psychotic they prefer, and their advocates/carers will be consulted where appropriate.

1.5 The main aim of administering these drugs is to prevent relapse and help keep the person stable enough to live as normal a life as possible.

2. Relapse Prevention: Depot anti-psychotics

2.1 The Responsible Clinician and the Multi-Disciplinary Team should always consider the benefits and risks regarding concordance with medication. Clinical rationales/risk management considerations etc. must be reviewed regularly at each CPA review and recorded in the clinical records / CPA. These decisions should be communicated appropriately to all relevant professionals.

2.2 Depot preparations should be a treatment option where a service user expresses a preference for such treatment because of its convenience, or as part of a treatment plan in which the avoidance of covert non-adherence with anti-psychotic drugs is a clinical priority.

2.3 For optimum effectiveness in preventing relapse, depot medications should be prescribed within the standard recommended dosage and interval range.

2.4 Following full discussion (Recorded in case notes and communicated) between the responsible medical officer/clinician and the service user, the decision to initiate depot injections should take into account the preferences and attitudes of the service user towards the mode of administration and the organisational procedures (e.g. home visits/location of clinics) related to the delivery of regular intramuscular injections.

2.5 When initiating depot/long-acting injectable antipsychotic medication:

- take into account the same criteria recommended for the use of oral antipsychotic medication, particularly in relation to the risks and benefits of the drug regimen
- Provide information and discuss the benefits and side-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional together, considering:
- the relative potential of individual antipsychotic drugs to cause extrapyramidal side effects (including akathisia), metabolic side effects (including weight gain) and other side effects (including unpleasant subjective experiences)
- the views of the carer if the service user agrees.

2.6 Before starting antipsychotic medication, it is recommended[1] the person has an electrocardiogram (ECG) if:

- specified in the Summary of Product Characteristics (SPC) www.medicines.org.uk/emc/
- a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure)
- there is personal history of cardiovascular disease, or
- the service user is being admitted as an inpatient.

3. Beginning Treatment with Depot Medication See Appendix B for risperidone long acting injection

3.1 Depots are long acting. Any adverse effects that result from injections are likely to be long lived**. Therefore a small test dose is essential to avoid severe or prolonged adverse effects.** (See latest BNF and manufacturer's information).

3.2 The test dose is used to gauge the acceptability to the service user of the injection being administered, and to observe for side effects.

3.3 Rarely, the oil vehicle used to dissolve the drug can lead to systemic reactions (anaphylaxis). Before administration the patient must be assessed, and known allergies detailed.

3.4 The test dose and the second dose (first treatment dose) should be administered in a clinic/GP surgery or other appropriate clinical setting, in case of adverse reactions. Patients should be observed for any immediate reactions, with close

monitoring over the subsequent days for other side effects such as EPSEs. After the test dose an interval of 4 – 7 days (refer to BNF or SPC) is needed before starting titration to maintenance therapy. Note: there is no test dose for Risperidone Long Acting Injection.
(Titration involves adjusting doses and assessing responses, to ensure the maintenance dose provides maximum therapeutic benefit with minimal side effects).

3.5 A test dose does not need to be re-administered providing the next dose is given within 30 days. If the time delay is greater than this, the patient should be re-assessed (by the care co-ordinator /named nurse in consultation with the prescribing doctor or nominated deputy), and a further test dose administered if a depot is still indicated.

3.6 All depots can be safely administered at their licensed dosing intervals. There is no evidence to suggest that shortening the dose interval improves efficacy. Moreover, injections can be painful, so less frequent administration is desirable.

3.7 The "observation" that some patients deteriorate in the days before the next depot can be misleading. Depending on the drug, interval and whether at steady state for some hours (or even days for some preparations) plasma levels of antipsychotics may continue to fall albeit slowly, after the next injection. Thus patients are more at risk of deterioration immediately after a depot injection, and not before it. Adjustment of the dose may be preferable to shortening of the interval.

3.8 In trials, relapse seems only to occur 3-6 months, (or longer) after withdrawing depot therapy; which is roughly the time required to clear steady state drug levels from the body.

3.9 Attainment of peak plasma levels, therapeutic effect and steady state plasma level are all delayed with depot medication. Doses may be **reduced** if adverse effects occur, but should only be increased after careful assessment over at least one month – preferably longer.

3.10 Once stabilised on depot medication it may be appropriate for some patients to receive their depot in primary care subject to a Shared Care Agreement being put in place.

4. Package of Care

4.1 The management of psychotic illness involves a comprehensive package of care with the aim of addressing all the service users' clinical, emotional and social needs. Pharmacological management centres on antipsychotic drugs, although drug therapy currently accounts for a relatively small proportion of the total health care costs of individuals with psychotic illness.

4.2 In a proportion of first episodes of acute psychosis, individual's first contact with mental health services result in "sectioning" under the Mental Health Act (1983). This limits the service user's ability to be involved in treatment decisions, which

in these circumstances are often made on their behalf by the clinician responsible for treatment, taking into account any advanced decisions and the Guiding Principals in the MHA Code of Practice

4.3 Individuals experiencing a first episode of psychotic illness are known to be more susceptible to the adverse effects of treatment, which may subsequently impact on their adherence to future therapy and on their longer term progress.

5. Side Effects of Anti Psychotic Medication

5.1 All antipsychotic agents are associated with side effects, but the profile and clinical significance of these varies among individuals and drugs.

5.2 Side effects may include Extra Pyramidal Symptoms (EPS) such as Parkinsonism, acute dystonic reaction, akathisia and Tardive Dyskinesia (characterised by abnormal masticatory movements and, in severe cases, choreiform trunk and limb movements). The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is a useful objective measure of the impact of these effects on the patient (see appendix D)

5.3 Autonomic effects, such as blurring of vision, dry mouth and eyes, constipation and urinary retention; increased intra-ocular pressure; increased prolactin levels (see appendix G); seizures; sedation and weight gain.

5.4 Cardiac safety is also an issue because several antipsychotics have been shown to prolong ventricular repolarisation (the QTc interval), which is associated with increased risk of ventricular arrhythmias and torsade de pointes. An ECG is now recommended before prescribing Haloperidol, and all antipsychotics available as depots are either contra-indicated or to be used with caution with other treatments that also extend QTc interval e.g. citalopram, escitalopram, methadone, antiarrythmics, antimalarials and some antibiotics (see Maudsley 11th ed. p. 115-120)

5.5 Antipsychotic drugs may take several weeks to control symptoms, and whilst some dosage adjustment may be required, the minimum effective dose possible should be used.

5.6 Doses should not normally be increased above the licensed dose range. If they are the reasons for this must be clearly documented in the service user's notes and the advice from the Royal College of Psychiatrists on doses above BNF upper limit followed (see Appendix C)

5.7 High doses increase the likelihood of side effects and this may limit benefit by reduction in concordance. Other antipsychotics should be considered rather than resorting to the use of higher standard doses.

5.8 If the service user experiences extra pyramidal side effects, anticholinergic drugs (e.g. Procyclidine, trihexphenidyl,) should usually be given immediately to reduce the unpleasant symptoms. These drugs should not be used if the symptoms of Tardive Dyskinesia are present as they can exacerbate the

condition. Tardive Dyskinesia is irreversible in 50% of cases. Appropriate medication (consult pharmacy) may reduce the abnormal movements of Tardive Dyskinesia, as may reduction or cessation of antipsychotics.

(The Responsible Clinician will always consider the side effects profile for service users and would usually follow good practice guidelines.)

5.9 Long term use of anticholinergic drugs should be avoided, as they too can have unwanted side effects (e.g. blurred vision, dry mouth, memory impairment), may be abused, may worsen or provoke Tardive Dyskinesia and in excess may provoke excitement and confusion.

5.10 Individuals suffering from schizophrenia consider the most troublesome side effects to be Extra Pyramidal Symptoms (EPS), weight gain, sexual dysfunction and sedation. EPS are easily recognised, but their occurrence cannot be predicted accurately and they are related to poor prognosis. Akathisia is also often missed or misdiagnosed as agitation. Of particular concern is tardive dyskinesia (orofacial and trunk movements), which may not be evident immediately, is resistant to treatment, may be irreversible, and may worsen on treatment withdrawal. Sexual dysfunction can result from drug-induced hyperprolactinaemia; it is likely be to an under-reported side effect of antipsychotic treatment, as discussion of this issue is often difficult to initiate.

6. Information for Service Users

6.1 Service users and their carers should be informed about, and understand, the mechanisms by which they can arrange to see the prescribing doctor.

6.2 Service users should understand the reasons why they receive injections, and be educated to recognise, monitor and report any side effects.

6.3 Service users must receive written information about the use of depot neuroleptics and the effects of the prescribed medication. The agreed source of information should be via the Medication A-Z on the NHS Choices website http://www.nhs.uk/medicine-guides/pages/default.aspx (available via the drop down menu on the front page of HealthNET). A Patient Information leaflet may be printed from this site.

7. Informed Consent

7.1 Guidance and support regarding consent should be given to service users before treatment commences.

7.2 If the service user is detained under the Mental Health Act (1983), medication for mental disorder can be prescribed and administered legally to patients to whom section 58 applies. (See “Safe and Secure Handling of Medication Policy”).

Section 58 applies to the administration of medication for mental disorder (except for medication administered as part of electro-convulsive therapy).But it only applies once three months have passed from the day on which any form of

medication for mental disorder was first administered to the patient during the patients current period of detention under the Act ("the three month period ").

For these purposes, the current period of detention continues even if the section under which the patient is detained changes. It also includes any time the patient has spent on Supervised Community Treatment (SCT)

7.3 The service user will initially be seen by the doctor prescribing the medication as part of a regular review (three monthly)**.** However, where a service user has been stable on this medication for six months, it is acceptable for the review of medication to occur at the 6 monthly CPA review.

Any issues that present should be documented and brought to the attention of the prescriber.

In any event the service user must be seen and examined by the Prescribing Doctor at least annually.

8. Care Co-coordinator/Named Nurse/Responsible Clinician/Team Manager

8.1 All service users receiving depot medication in whatever setting should have access to an identified named nurse or care coordinator/Responsible Clinician/Lead Professional whom, where possible, should be the gender of their choice.

8.2 The patient's GP should be informed that the patient has been prescribed a depot. Once stabilised on an effective dose some patients may be suitable to receive their depot from their GP surgery with the agreement of their GP.

8.3 If the named nurse is not the Care co-ordinator under the Care Programme Approach, he or she must take responsibility for informing the service users Care co-ordinator / Lead Professional and the prescribing doctor/GP if appointments are missed or an injection refused.

8.4 It is the responsibility of the Care coordinator to advise /involve the prescriber and their service area manager or line manager if the service user is non compliant.

8.5 It is the responsibility of line managers in the community to review depot medication administration monthly (as part of case load supervision) for all service users on the care coordinators/CPNs caseload.

8.6 The team manager is responsible for ensuring an annual audit of all depot medication cards is carried out using the attached audit tool (see Appendix A).

9. Staff Training

9.1 Depot Antipsychotics must only be administered by a Registered Nurse or doctor who has been verified as competent in the administration of intramuscular medication. (Student nurses may carry out this procedure under the direct supervision of a trained nurse). (See Procedures in Appendix E)

9.2 A treatment strategy based solely on depot neuroleptics is inadequate, inappropriate and fails to meet service users' aspirations. Therefore, it is essential that the training needs of staff working in the service are regularly reviewed in order to expand the repertoire of interventions which staff can draw on in their work with service users receiving this form of treatment.

9.3 It is essential that the staff involved with the service users are fully conversant with the aims, possible side effects and contra-indications of each prescription they administer.

9.4 It may be appropriate for mental health and learning disabilities staff to provide members of the primary health care team with support/training and supervision in this area.

9.5 The support / training and supervision to be provided should be detailed in the patient's clinical record and agreed by the appropriate Mental Health /Learning Disabilities practitioner and the named Primary Care practitioners.

9.6 If Depot neuroleptics are being administered in Primary Care, by Primary Care staff; the Primary care staff must have speedy and responsive access to the Secondary Care team who handed over this aspect of the care to them; there must be an identified named professional with whom they can make contact and get advice/support with any queries or concerns, within an agreed timescale.

9.7 The training of mental health service staff in a range of psychosocial interventions, and their full involvement in liaison with primary health care teams and practice nurses will provide opportunities to offer complementary strategies for preventing relapse.

10. Service Outlets and Environments

10.1 Depot medication should be part of a comprehensive package of care that addresses the individual's clinical, emotional and social needs. The clinician responsible for treatment and the care coordinator/lead professional should monitor both the therapeutic progress and the tolerability of the drug on an ongoing basis. Part of this monitoring involves checking that the organisational arrangements, such as where and when the service user receives their injections are as convenient and acceptable as possible.

10.2 Appropriate space, privacy and adequate time should be provided when giving a depot, whether this is in a local, user friendly, non stigmatising clinical environment or within the service users own home/preferred environment.

Appendix A

Practice Guidelines

See Appendix B for risperidone long acting injection

The Administration of Depot Medication

- Depot medication must be administered by a trained nurse/doctor (ideally the care co-ordinator/named nurse), who is competent in the administration of depot neuroleptics.
  (Student nurses may carry out this procedure under the direct supervision of a trained nurse)

Before administration of medication, the nurse must ensure correct identification of the service user using name and NHS number

- Rarely, the oil vehicle used to suspend the drug can lead to systemic reactions (anaphylaxis). Before administration the patient must be assessed, and known allergies detailed. Contact pharmacy for information on individual formulations. The nurse must have attended regular approved Anaphylaxis Training as per LSW Management of Severe Anaphylaxis Protocol.

- The nurse will ensure that the service user has received all information regarding the risks and benefits of the medication, including appropriate written information about the use and effects of depot neuroleptics, (evidence of this must be recorded in the clinical notes).

- There must be written evidence (via care plan/and detailed in notes) that the service user has consented to receive the treatment, or if detained under the Mental Health Act that the appropriate consent to treatment exists.

- For community patients the prescription must be written on a Depot Neuroleptic Prescription Card which must be completed with the Service Users personal details, including Patient NHS Number. The depot neuroleptic prescription card must be current, have a review date (maximum 3 months), and be signed and dated by the Medical Officer. Please note separate procedures apply for Risperidone Long acting Injection – see appendix B.

- For inpatients the depot section of the Mental Health Prescription Chart must be used. It is also good practice to include the name of the depot on the regular section of the inpatient prescription chart with a note “see depot section” as an additional cross-reference.

- When/if there is a possibility that duplicate prescriptions might exist, or indeed that the depot prescription might have been cancelled or changed during an inpatient admission, it is crucial that the community care coordinator and the named nurse in the hospital liaise effectively to avoid drug errors. **When patients are discharged it is essential that the community depot card is**

brought up to date by the prescriber with any changes made during the admission.

- Before administering the depot, the registered nurse, who should ideally be a permanent member of the Trusts staff must assess the service user, taking the bullet points below into consideration and documenting where appropriate.

    - The service users current health/mental health status
    - Concurrent medication
    - Any evidence of side effects from the medication
    - The service users current wishes, feeling and rights in relation to the treatment
    - Whether a consultation with the doctor needs to be arranged

- All agency or locum nursing staff must be given this policy as part of their induction protocol. (The nurse's experience and subjective view of competence should be checked and the offer of supervised practise made).

- If medication is refused or withheld, the nurse must ensure that this is accurately recorded, reported and discussed with the GP, Responsible Clinician or nominated deputy.

- The care co-coordinator and the doctor are responsible for deciding what action to take if the service user has defaulted. If the Care Co-ordinator is not the person administering the depot, the administering nurse must personally inform the patients Doctor and Care Co-ordinator/lead professional or their deputies, as soon as is practicable, that the patient has defaulted.

- The service area manager(care coordinators/lead professionals line manager) must be informed if a service user has defaulted, either during regular monthly case load supervision sessions or more immediately if the risk issues identified are high.

- The medication must be administered following the guidelines for the administration of injection by intramuscular route (see Appendix E), taking into consideration the service users preferences.

- An accredited monitoring tool (such as AIMS/Lunsers – see Appendix D) may be used to ensure a systematic, more objective measure of the service user's response to the medication, and their progress generally is maintained.

  It is the responsibility of line managers in the community to review depot medication administration monthly (as part of case load supervision) for all service users on the care coordinators/CPNs caseload.

- The team manager is responsible for ensuring an annual audit of all depot medication cards is carried out using the attached audit tool (see appendix)

Appendix B

Risperidone Long Acting Injection Prescribing Guidelines

Contact Details:

Pharmacy Technician (ordering queries)	LCC (4)34725; Glenbourne: (4)39006 Bleep 85222 via Mount Gould 0845 155 8100
Pharmacists in Mental Health (clinical queries)	LCC (4)34723; Glenbourne: (4)39006 Bleep 85225 / 85189 via Mount Gould 0845 155 8100
Pharmacy Office Fax Number	(27)2437

Note:

- All staff administering Risperidone long acting injection (Risperdal Consta®) must have received training either from a qualified nurse who is competent in its administration or directly from Janssen. This training is free and carried-out by the company representative. Tel. 01494 567 567 for details of the hospital representative.
- The specific administration instructions from Janssen must be followed
- There is no test dose for Risperidone long acting injection (see below). The first dose should be administered in a clinical setting. Note that the first dose will not have released before the second dose is given, therefore continue to be vigilant for adverse symptoms
- **For acute inpatients and those cared for by Home Treatment Team** Risperdal Consta® is ordered by the Pharmacy technician, direct from Janssen. It is delivered in a refrigerated van within 2 days of placing the order. Risperdal Consta® should not be ordered from Derriford Pharmacy as they cannot provide cold chain transportation.
- Please inform the Pharmacy Technician immediately if the supply of Risperidone long acting injection needs to be delivered to a different base (e.g. discharge from ward, or move between community teams)
- If Risperidone long acting injection is discontinued, please notify the Pharmacy Technician as soon as possible so that supply can be cancelled.
- **For patients in the community or in a long stay recovery unit** Risperdal Consta® is supplied by Polarspeed Dispensing Service. This allows named supplies to be supplied via refrigerated vans to team bases and is provided free from VAT as per Inland Revenue rules.
- Each team or unit is registered with Polarspeed and a registration form has to be completed for each patient. Risperdal Consta® must be prescribed on a Polarspeed prescription which must be renewed every six months.
- Full details of the Polarspeed service and the appropriate forms are provided in appendix F.

a) Beginning treatment with risperidone long acting injection

See the flow diagram on p. 20

b) Switching to risperidone long acting injection

- **From oral risperidone:**

NB: if the patient is stabilised and compliant with oral risperidone do not use the injectable form unless this is the patient's preference.

Start Risperidone long acting injection at any time but continue oral risperidone for 3 to 5 weeks after first injection, then review. Withdraw the oral risperidone gradually.

- **From other oral antipsychotic:**

  Patients with no previous history of risperidone use should be pre-treated with oral risperidone for several days (e.g. 2mg daily for minimum of 2 to 3 days) as clinically feasible, to assess tolerability before the first injection. If this is not possible then a single dose of risperidone can be given to test for hypersensitivity.

  Start Risperidone long acting injection at any time but continue the oral antipsychotic for 3 to 5 weeks after the first injection of Risperidone long acting injection then review. Withdrawn the oral antipsychotic gradually.

- **From another depot antipsychotic:**

  Patients with no previous history of risperidone use should be pre-treated with oral risperidone for several days (e.g. 2mg daily for minimum of 2 to 3 days) as clinically feasible, to assess tolerability before the first injection. If this is not possible then a single dose of risperidone can be given to test for hypersensitivity.

  Give the first dose of Risperidone long acting injection in place of the next dose of the current depot (i.e. on the next due date). It may also be necessary to give oral risperidone for the first 3 weeks or more – this will need to be considered according to the individual's symptoms. Withdraw any oral risperidone gradually.

- **Medication-free patients:**

  Patients with no previous history of risperidone use should be pre-treated with oral risperidone for several days (e.g. 2mg daily for minimum of 2 to 3 days) as clinically feasible, to assess tolerability before the first injection. If this is not possible then a single dose of risperidone can be given to test for hypersensitivity.

  Start Risperidone long acting injection at any time. If possible continue oral risperidone for 3 to 5 weeks after first injection, then review. Withdraw the oral risperidone gradually.

NB: For some patients it may be necessary to continue to supplement the Risperidone long acting injection® injection with oral risperidone (max 4mg/day) until the optimal dose of Risperidone long acting injection® is reached.

c) Dosing

For those patients stabilised on a fixed dose of oral risperidone for two weeks or more, the following conversion scheme should be considered:

- Patients treated with a dosage of 4 mg or less oral risperidone should receive 25 mg Risperidone long acting injection

- Patients treated with higher oral doses should be considered for the higher Risperidone long acting injection dose of 37.5 mg.

Give by deep IM injection (release differs in fat layers). Reconstitute following the manufacturer's instructions and **give the whole contents of the vial.** Use this dose for at least 3 doses so that steady-state is reached.

Titrate the dose if necessary by increments of 12.5mg (i.e. 37.5mg or 50mg every 2 weeks). Allow at least 4 weeks between dose changes. Do not exceed 50mg every 2 weeks. Do not alter the frequency of the injection because of the unique formulation of the product.

d) Side-effects see Risperidal Consta ® SPC: http://www.medicines.org.uk/EMC/medicine/9939/SPC/RISPERDAL+CONSTA+25%2c+37.5+and+50+mg+powder+and+solvent+for+prolonged-release+suspension+for+intramuscular+injection/

e. Special precautions for storage

The entire pack should be stored in a refrigerator (2°C to 8°C). The pack should be taken out of the refrigerator for at least one hour before administration to the patient.

If refrigeration is unavailable, or it is not possible to maintain the cold chain during delivery, Risperidone long acting injection can be stored at room temperature (not exceeding 25°) for no more than 7 days prior to administration. After 7 days at room temperature the injection must be destroyed as per LSW policy. Do not return to the fridge and do not administer to a patient.

Note: Where the cold chain cannot be guaranteed between the supplier and the ward/ CMHT, an expiry date of 7 days will be given from the dispensing date.

f. Handling and use

Risperidone long acting injection powder may **only** be suspended in the solvent for risperidone long acting injection supplied in the dose pack and must be administered with the needles supplied in the dose pack. The manufacturer's information must be followed accurately.

Livewell Southwest

Risperidone Long Acting Injection Prescribing Guidelines

Revised October 2012

Beginning Treatment with Risperidone Long Acting Injection

Inpatient Initiation (including HTT but not Recovery Units)

Prescribe risperidone long acting injection on the depot section of Mental Health Drug Chart and also in the regular section of the chart with a note "see depot section" Follow guidelines for switching to risperidone long acting injection

Mental Health Pharmacist screens chart and informs technician, who checks ward fridge for stock and compiles order for Janssen, to be faxed once per week where possible (minimum order for 25mg strength is 2 packs)

Nurse administers risperidone long acting injection (must have received training in its administration -see Policy) Ensure facilities for resuscitation are available

Ensure injection is refrigerated immediately on receipt and delivery note is sent to Pharmacy Services at Mount Gould Hospital

As with all antipsychotics, wherever possible perform baseline tests repeated as necessary (e.g. see Maudsley 11th ed. p.27- 30)
If prolactin is raised consult the notes in the Prescribing Guidelines

The starting dose of risperidone long acting injection is 25mg every 2 weeks (equivalent to approx. 4mg/day of oral risperidone). In patients on a dose higher than 4mg/day consider starting on 37.5mg every 2 weeks
Remain at the starting dose for at least 3 injections, to allow steady-state to be reached. After this, increase the dose if necessary in increments of 12.5mg, but allow at least 4 weeks at each dose level before assessing any change or further increasing the dose.
Maximum dose is 50mg every 2 weeks (25mg in the elderly). The dosing interval must be every 2 weeks.
If switching from oral antipsychotics continue oral antipsychotic cover for 3 to 5 weeks after first risperidone long acting injection

Patients transferred to Home Treatment Team should continue to be supplied by Janssen but on discharge to a community team must be transferred to Polarspeed prescription

The injection is available in 25mg, 37.5mg and 50mg strengths.
The complete injection must be given due to the formulation of the product.

Community Initiation (including Recovery Units)

Prescribe risperidone long acting injection on Polarspeed prescription and fax to Polarspee
new patients a registration form needs to be complete
hard copies immediately in the post. Also ens
Neuroleptic Card or Depot section of Drug Ch
completed as appropriate. Follow guidelines
to risperidone long acting injection

Administer first dose of risperidone long acting in clinic area, or where emergency support/eq is available. Follow Trust Depot Policy

Subsequent doses will be sent every 2 week Polarspeed (they will check it is still needed) months unless cancelled.
Ensure injection is refrigerated immediately and delivery note is sent to Pharmacy Servic Mount Gould Hospital

Appendix C

Advice of Royal College of Psychiatrists on Doses above BNF Upper Limit

Unless otherwise stated, doses in the BNF are licensed doses—any higher dose is therefore **unlicensed**

1. Consider alternative approaches including adjuvant therapy and newer or second generation antipsychotics such as clozapine.
2. Bear in mind risk factors, including obesity—particular caution is indicated in older patients especially those over 70 – reduce the initial dose to half the adult dose or less, taking into account patient's weight, co-morbidities and concomitant medication.
3. Consider potential for drug interactions – see appendix 1 of the BNF
4. Carry out ECG to exclude untoward abnormalities such as prolonged QT interval; repeat ECG periodically and reduce dose if prolonged QT interval or other adverse abnormality develops.
5. Increase dose slowly and not more often than once weekly.
6. Carry out regular pulse, blood pressure, and temperature checks; ensure that patient maintains adequate fluid intake.
7. Consider high-dose therapy to be for limited period and review regularly; abandon if no improvement after 3 months (return to standard dosage).
8. **Important:** When prescribing antipsychotics for administration on an emergency basis, the intramuscular dose should be lower than the corresponding oral dose (owing to absence of first pass effect), particularly if the patient is very active (increased blood flow to muscle considerably increases the rate of absorption). The prescription should specify the dose for each route and should not imply that the same dose can be given by mouth or by IM injection. The dose of antipsychotic for emergency use should be reviewed at least daily.

Ref: British National Formulary (BNF) 64 Sept 2012 Section 4.2

Royal College of Psychiatrists: Consensus Statement on high-dose antipsychotic medication. Council report CR138 May 2006

Appendix D

Lunsers

Liverpool University Neuroleptic Side Effect Rating Scale

The following pages are a copy of the LUNSERS, which is fully validated, and reliable means of assessing neuroleptic side effects. It includes 41 known side effects of neuroleptics and 10 “red herring” items such as hair loss and chilblains, which are not known side effects of neuroleptic medication. The red herring items are numbers 3, 8, 11, 12, 25, 28, 30, 33, 42, and 45. These should be scored separately as this score may indicate individuals who overscore generally on the scale (a high score would be over 20 for example). The scoring is as follows:

Not at all = 0
Very little = 1
A little = 2
Quite a lot = 3
Very much = 4

The real narcoleptic side effect score is the sum for the remaining items (all items excluding the red herrings).

Possible range for Total Scores

LUNSERS side effect scores only
Females = 0 – 164
Males = 0 – 156

LUNSERS all 51 items (Including red herrings)
Females = 0 – 204
Males = 0 – 196

LUNSERS

Name: _____ NHS No. _____

Assessment No Assessment Date / /

	Please indicate how much you have experienced each of the following symptoms in the last month by ticking the appropriate boxes	Not At All	Very Little	A Little	Quite A Lot	Very Much
1	Rash					
2	Difficulty in staying awake during the day					
3	Runny Nose					
4	Increased Dreaming					
5	Headaches					
6	Dry Mouth					
7	Swollen or tender chest					
8	Chilblains					
9	Difficulty in concentrating					
10	Constipation					
11	Hair Loss					
12	Urine darker then usual					
13	Period Problems					
14	Tension					
15	Dizziness					
16	Feeling sick					
17	Increased sex drive					
18	Tiredness					
19	Muscle stiffness					
20	Palpitations					
21	Difficulty in remembering things					
22	Loosing weight					
23	Lack of emotions					
24	Difficulty in achieving climax					
25	Weak fingernails					
26	Depression					
27	Increased sweating					
28	Mouth ulcers					
29	Slowing of movements					
30	Greasy skin					
31	Sleeping too much					
32	Difficulty in passing water					
33	Flushing face					
34	Muscle spasms					
35	Sensitivity to sun					
36	Diahorrea					
37	Over-wet or drooling mouth					
38	Blurred vision					
39	Putting on weight					
40	Restlessness					
41	Difficulty getting to sleep					
42	Neck muscles aching					
43	Shakiness					
44	Pins and needles					
45	Painful joints					
46	Reduced sex drive					
47	New or unusual skin marks					
48	Parts of body moving on there own accord. E.g. Foot moving up or down					
49	Itchy skin					
50	Periods less frequent					
51	Passing a lot of water					

Allergic Reaction

1 Rash
2 Sensitivity to sun
47 New or unusual skin marks
49 Itchy skin

Possible range 0-16

Psychic side effects
2 Difficulty staying awake during the day
4 Increased dreaming
9 Difficulty in concentrating
14 Tension
18 Tiredness
21 Difficulty in remembering things
22 Lack of emotion
26 Depression
31 Sleeping too much
41 Difficulty getting to sleep

Possible range 0-40

Hormonal side effects

7 Swollen or tender chest
13 Period problems **FEMALE ONLY**
17 Increased sex drive
23 Difficulty in achieving climax
46 Reduced sex drive
50 Periods less frequent **FEMALE ONLY**

Possible range Females 0-24 Males 0-16

Miscellaneous

5 Headaches
22 Losing weight
39 Putting on weight
44 Pins and needles

Possible range 0-16

Red Herrings

3 Runny nose
8 Chilblains
11 Hair loss
12 Urine darker than usual
25 Weak fingernails
28 Mouth ulcers
30 Greasy skin
33 Flushing of face
42 Neck muscles aching
45 Painful joints

Possible range 0-40

Appendix E

The Administration of Depot Medication in Mental Health Services Intra muscular injection technique guidelines.

Reader Information

Document Purpose and Description	To advise staff regularly administering depot medication of the appropriate, clinically appropriate sites.
Author(s)/Editor(s)	Training & Development Manager MH Partnership
Job Title of Person Responsible for Review	Deputy Director of Nursing Training & Development Manager MH Partnership
Target Audience	Registered Medical and Nursing staff in Mental Health Services
Consultation Process	• MH Directorate Managers • MH Directorate Matrons • MH Pharmacy

The Administration of Depot Medication in Mental Health Services - Guidelines

E1 Introduction & Purpose

The Purpose of this appendix is to provide registered nursing staff and medical practitioners, who have responsibility and accountability for the administration of depot medication with appropriate guidance as to the sites recommended for the delivery of this medication, safely and effectively and assessing patients' physical suitability.

Intramuscular injections (IMI) are frequently referred to as a 'basic skill' but involve a complex series of considerations and decisions relating to:

- Volume of injectate;
- Medication to be given;
- Technique;
- Site selection;
- Equipment.

Other considerations are patients' age, physical build and pre-existing conditions such as bleeding disorders, and the environment where the injection is given (Plotkin et al, 2008).

Each patient must be assessed individually each time for the receipt of IM injection by the administering practitioner taking into account all aspects of anatomy and physiology of the preferred site, height, weight and build may assist in making these decisions but should not be taken to be the sole guide (BMI may be high 30+ in individuals who may be overweight/obese as well as people who are very muscular), the patients' mental health at the time of injection, volume of injectate and carrier solution (oil/water).

E3 Intra Muscular guidelines.

3. Injection sites

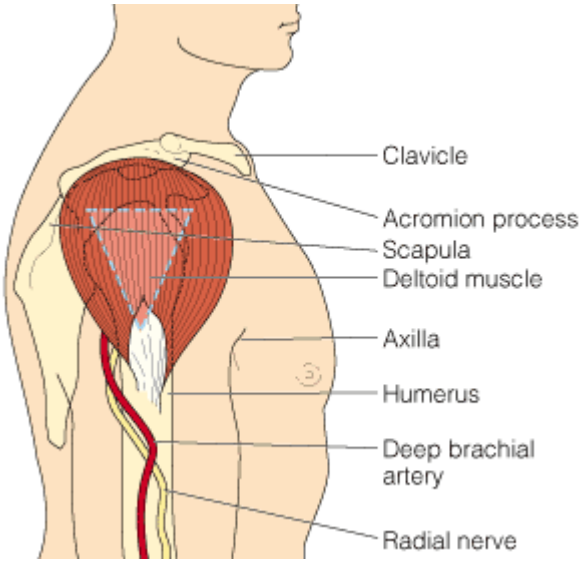
3.1 Current research evidence suggests that there are five sites that can be utilised for the administration of intramuscular injections (Workman 1999; Rodger & King 2000)

The five sites are:

The mid-deltoid site (Fig. a)
The dorso-gluteal site (Fig. b)
The rectus femoris site (Fig. c)
The vastus lateralis site (Fig c)
The ventro-gluteal site (Fig. d)

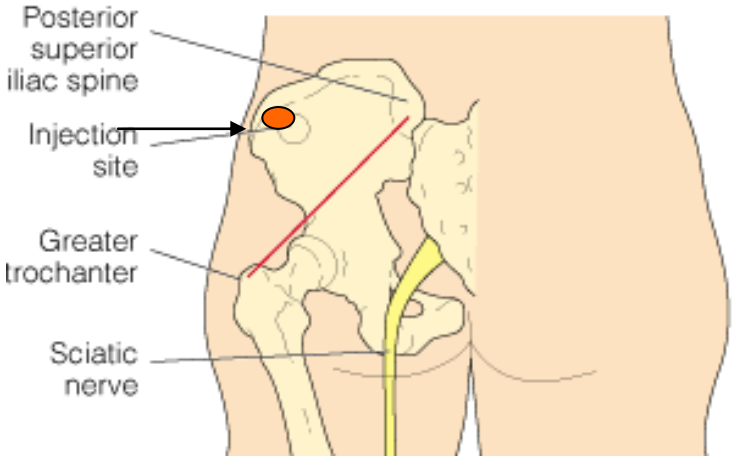
Livewell Southwest endorses the Ventrogluteal* and Dorsogluteal* as intramuscular injection sites of choice.

3.1.2. The mid-deltoid site (Fig. a). This site is used for the injection of such drugs as narcotics, sedatives, absorbed tetanus toxoid, vaccines and vitamin B12. This is a better site than the gluteal muscles for small volume (less than 2ml) and rapid onset injections as the deltoid has the greatest blood flow of all the muscle groups used for intramuscular injections. Owing to the small area of this site, the number and volume of injections which can be given into it are limited. This site has the advantage of being easily accessible whether the patient is standing, sitting or lying down.



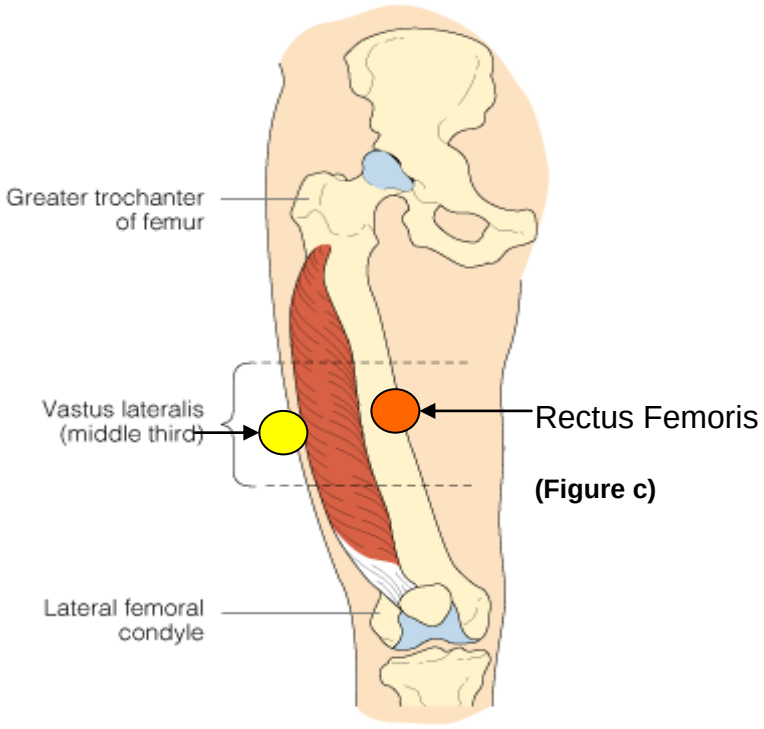
(Figure a)

3.1.3. The dorso-gluteal site (Fig. b)* is used for deep intramuscular and Z-track injections. It is commonly known as the 'upper outer quadrant'. The gluteal muscle has the lowest drug absorption rate and there is a thicker layer of adipose tissue present. The muscle mass is also likely to have atrophied in older people, non-ambulant and emaciated patients. This site carries with it the danger of the needle hitting the sciatic nerve and the superior gluteal arteries (Workman, 1999) therefore the landmarks of the site need to be accurately identified.



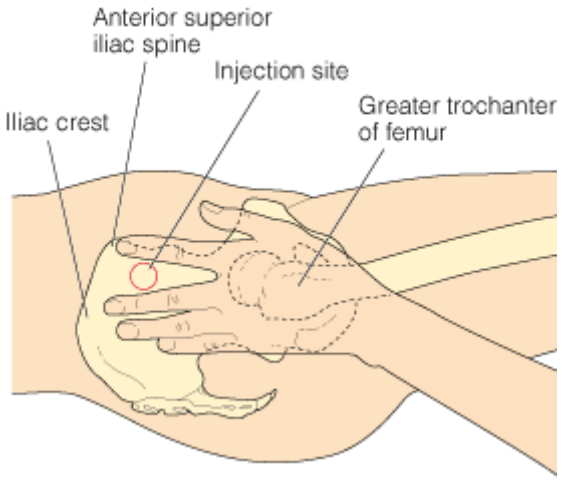
(Figure b)

3.1.4. The rectus femoris site (Fig. c) is used for anti-emetics, narcotics, sedatives and injections in oil. The rectus femoris is the anterior quadriceps muscle, which is rarely used by nurses, but is easily accessed for self-administration on injections or for infants (Workman, 1999).



(Figure c)

3.1.5. The ventro-gluteal site (Fig. d)* is used for antibiotics, antiemetics, deep intramuscular and Z-track injections in oil, narcotics and sedatives. This is the site of choice for intramuscular injections (Rodger & King, 2000) as up to 2.5 ml can be safely injected. The ventro-gluteal site provides the greatest thickness of gluteal muscle (gluteus medius and gluteus minimus) is free of penetrating nerves and blood vessels, and has a narrower layer of fat of consistent thinness.



(Figure d)

- Position client in supine lateral position. (lying flat, face up). Locate site by placing the hand with heel on the greater trochanter and thumb toward umbilicus. Point to the anterior iliac spine with the index finger (forming a "V"). Injection of medication is given within the "V" area.

3.2 Administering an IM injection

Also refer to main document section 11.1 'The Administration of Depot Injection'.

A registered practitioner who is undertaking the administration of a depot or other long-acting antipsychotic intramuscular injections must have:-

- A knowledge and understanding of the legislation, regulation and guidance applicable to this intervention.
- Knowledge of the licensed indication, contraindications, side-effects and interactions of the injection being administered.
- Regular approved Anaphylaxis Training as per LSW Management of Severe Anaphylaxis Protocol.
- Been assessed as competent in the technical performance of the intervention to ensure nothing is overlooked during the preparation, administration and following the procedure.

3.2.1. General Preparations:

- Promote patient comfort and relaxation
- Explain reason for injection: The patient should receive written and/or verbal information about their medications including potential benefits and adverse effects.
- Describe the procedure /obtain informed consent
- Check for any allergies/history of anaphylaxis
- Check prescription/drug/patient identification
- Check expiry dates and record lot numbers
- Avoid overexposure of patient
- Positioning of patient
- Infection Prevention and Control procedures **must** be adhered to. http://www.plymouthpct.nhs.uk/CorporateInformation/policiesprocedures/Documents/Clinical%20Guidance/IPC%20v3.pdf
- Staff hand washing and patient skin preparation procedures. http://www.plymouthpct.nhs.uk/CorporateInformation/policiesprocedures/Documents/Clinical%20Guidance/Hand%20Hygiene%20v6.1%20PCT.pdf

- **Community staff**

All injectable drugs must be safely transported in a case, specific for this purpose and which includes the sharps box and hand wash equipment. The case must be kept out of site in the boot of the car. Medicines must not routinely be stored in a car as fluctuations in temperature will make storage conditions unsuitable.

3.2.2. Medication Record

Any activity related to review or administration of medication given via intramuscular route, shall be recorded on the users care notes and depot medication chart where appropriate.

3.2.3. Administration

The administering nurse must: -

1. Ensure the treatment is accurately recorded on the depot neuroleptic card, including date due, approved name of depot and dose, date given, manufacturer's name, batch number and expiry date. The entry must be signed with full name and status and a record of which side the depot was administered.

2. Ensure correct disposal of equipment observing appropriate sharps procedures as per the Safe Disposal of Sharps Policy Version No 6.1

3. Ensure that the privacy and dignity of the service user is upheld at all times.

4. The nurse who carried out the injection must make document in the service user's notes detailing that the depot has been given, the site in which it has been given, also noting left or right area, and recording details of the nursing assessment undertaken.

5. If the service user has been seen by the prescribing doctor before attending for the injection, the nurse obtains from the doctor confirmation of results of the consultation and, in writing, any changes to the prescription.

6. IM injections should be administered in the **ventrogluteal** site whenever possible.

7. The medication should be administered with a needle long enough to reach the muscle without penetrating underlying structures, this assessment depends on the patient, substance to be injected (viscosity of injectate, is it oil or other fluid carrier?) and site to be used.

8. The gauge of needle can be 21SWG (G) up to 25SWG (G) and should have the appropriate safety devices attached as per safety regulations to prevent needle stick injury and in line with Organisations policy for the 'Safe Disposal of Sharps'.

Standard Wire Gauge (SWG)	Colour of hub		Standard Wire Gauge (SWG)	Colour of hub		Standard Wire Gauge (SWG)	Colour of hub
18	Pink		22	Black		26	Brown
19	Ivory/White		23	Blue		27	Grey
20	Yellow		24	Violet		30	BYellow
21	Green		25	Orange			

i. A needle length of 4cm (1.5 inches) for the average sized adult;
ii. Shorter needle for thinner individuals and children. 2.54cm (1 inch)
iii. Larger patients **may** require a needle that is longer than 4cm (1.5 inches) to ensure the needle makes it through the adipose tissue (fat). A 5cm (2 inch) needle may be suitable based on the structured clinical judgment of the registered professional based on physical observation of the patients build also using weight and BMI calculations to assist in that judgment.
iv. To insist on using 1.5" safety needles in these patients risks treatment failure as the needle may not reach the muscle and there is little or no absorption of antipsychotic depots from subcutaneous fat. Practitioners must take all precautions to prevent needle stick injury when using standard needles.

Be sure that the angle of all ventrogluteal injections is at 90 degrees to the skin.

9. The person administering the injection needs to demonstrate clear clinical rationale and decision making process as to the choice of equipment (needle size and site)

10. The practitioner will need to rotate injection sites, alternating between the left and right sides of the body and recording the side used on each occasion. The practitioner should check the site and side used last time to ensure alternation.

11. The patient should be positioned so as to relax the muscle, if using dorso gluteal, ventro gluteal , vastus lateralis or rectus femoris in a standing position , get the patient to raise the leg in which the injection is to be given to relax the muscle. If using the deltoid, get the patient to sit and place the arm across the waist.

12. The 'Z track' technique should be used at all times. (see 3.2.4)

13. These measures should ensure optimal nursing care for patients.

14 Sharps must be disposed of in accordance with the Safe Disposal of Sharps Policy Version No 6.1

3.2.4. 'Z Track' Technique

1. Place the outer side of your non-dominant hand (not the one you would use for

delivering the injection) on the chosen injection site.

2. Pull the skin downwards or to one side of the injection site.

3. Hold the needle at 90 degrees (right angle) to the skin.

4. Plunge the needle in quickly, penetrating the muscle and leaving about a third of the needle exposed.

5. Pull back the plunger to observe for blood aspiration.
    a) If blood is aspirated, all the equipment must be discarded and the whole procedure started again. The opposite site to be used if this occurs.
    b) If no blood is aspirated, slowly and continuously inject the drug over about 10 seconds. After about 10 seconds, withdraw the needle at the same angle at which it went in.

6. Release the skin. This has the effect of breaking the needle track or sealing off the puncture tract as the skin and subcutaneous layers move back over the muscle. The drug is therefore locked within the muscle.

3.2.5. Training & Supervision

1. Training in the administration of Deltoid, Ventrogluteal and Dorso Gluteal sites will be given to qualified medical and nursing staff.

2. The training will include the theory of the process, anatomy of the areas, practical identification of sites using an anatomically correct simulator under the supervision of a properly qualified and experienced practitioner.

3. Staff will demonstrate competence before transferring the skills to patient care.

4. Supervision of practice will be provided through the line management process.

3.2.6. Variations to practice:

1. Variations or exceptions to the described practice will only be allowed in the following circumstances:-

- Through reaction to pain at the site where an alternative site may be better indicated.

- Effectiveness of medication given through this site.

- In circumstances where the clinical presentation does not allow the patient to physical present in an appropriate manner e/g/ in situations of physical restraint being employed.

E4 Monitoring Compliance and Effectiveness

Clinical Audit is a part of the risk management process that supports using information positively to improve practice through learning from practice outcomes.

All untoward incidents that arise as a result of the care pathway within this document must be individually and collectively reviewed to provide sufficient knowledge to inform remedial action where necessary.

The National Patient Safety Agency advises healthcare organisations to undertake an audit of medicines practice relating to injections every year and develop an action plan to improve local practice as a result of this.

A template to undertake this is available from:
www.npsa.nhs.uk/nrls/alerts- and- directives/alerts/injectable- medicines/

This audit should cover all aspects of medication practice and patient safety data for injectable medicines

Internal depot medications audit process.

E5 Associated Documentation

These guidelines must be read in conjunction with the following Trust Policies and Guidelines:

Trust:

- Infection Prevention and Control Policies:
  - Hand Hygiene
  - Inoculation Injuries (the management of) Version No 8.2
  - Safe Disposal of Sharps Version No 6.1
- Medicines Management Procedure Version No 3
- Safe and Secure Handling of Medicines Guidelines Version No 5:9

All available at:
http://www.plymouthpct.nhs.uk/CorporateInformation/policiesprocedures/Pages/clinicalguidance.aspx

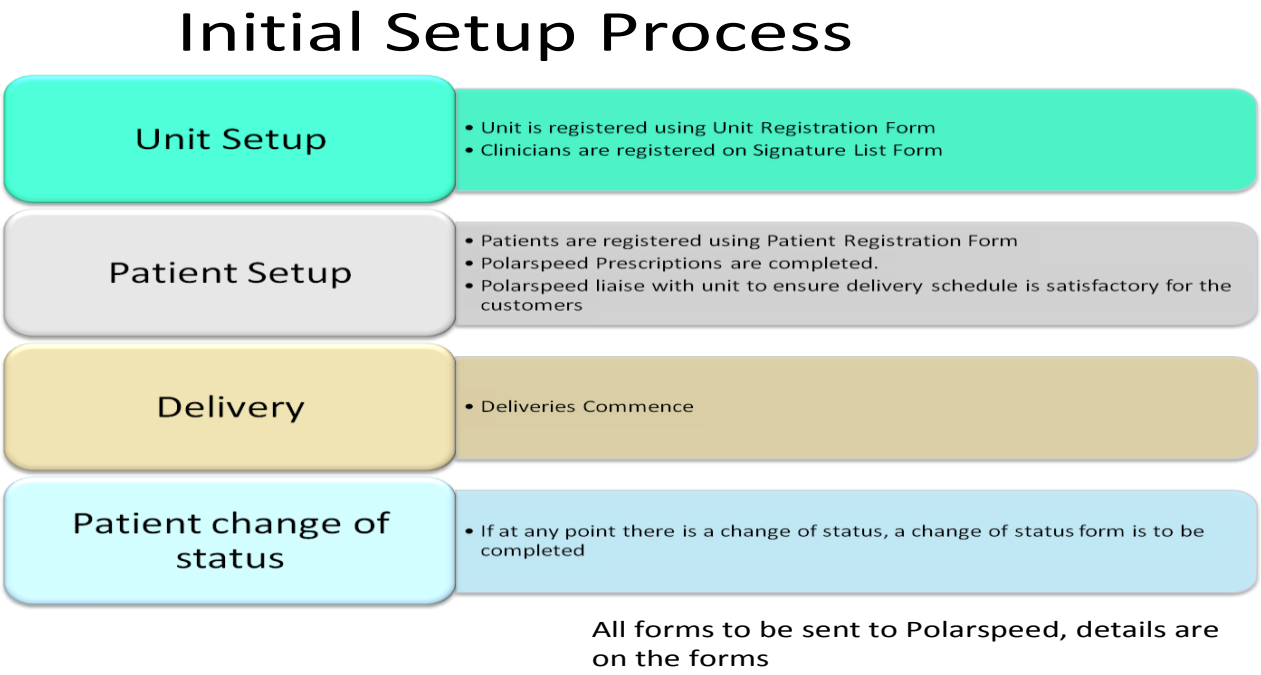
Others:

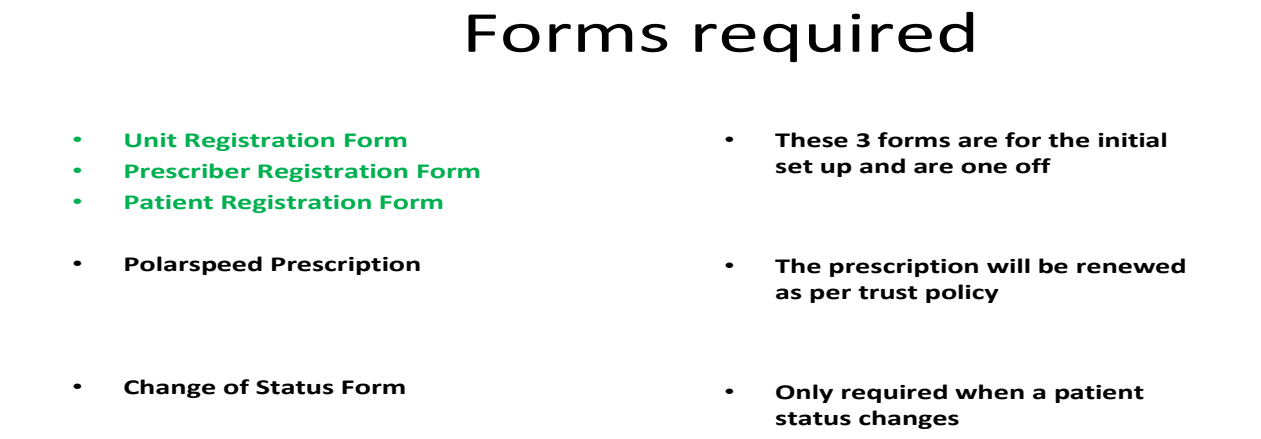
- Guidance on the Administration to Adults of Oil- based Depot and other Long- Acting Intramuscular Antipsychotic Injections (June 2009) UKPPG (United Kingdom Psychiatric Pharmacy Group) commissioned by Janssen Cilag Ltd.
  http://www.ukppg.org.uk/long- acting- injections- guidelines- sops.html

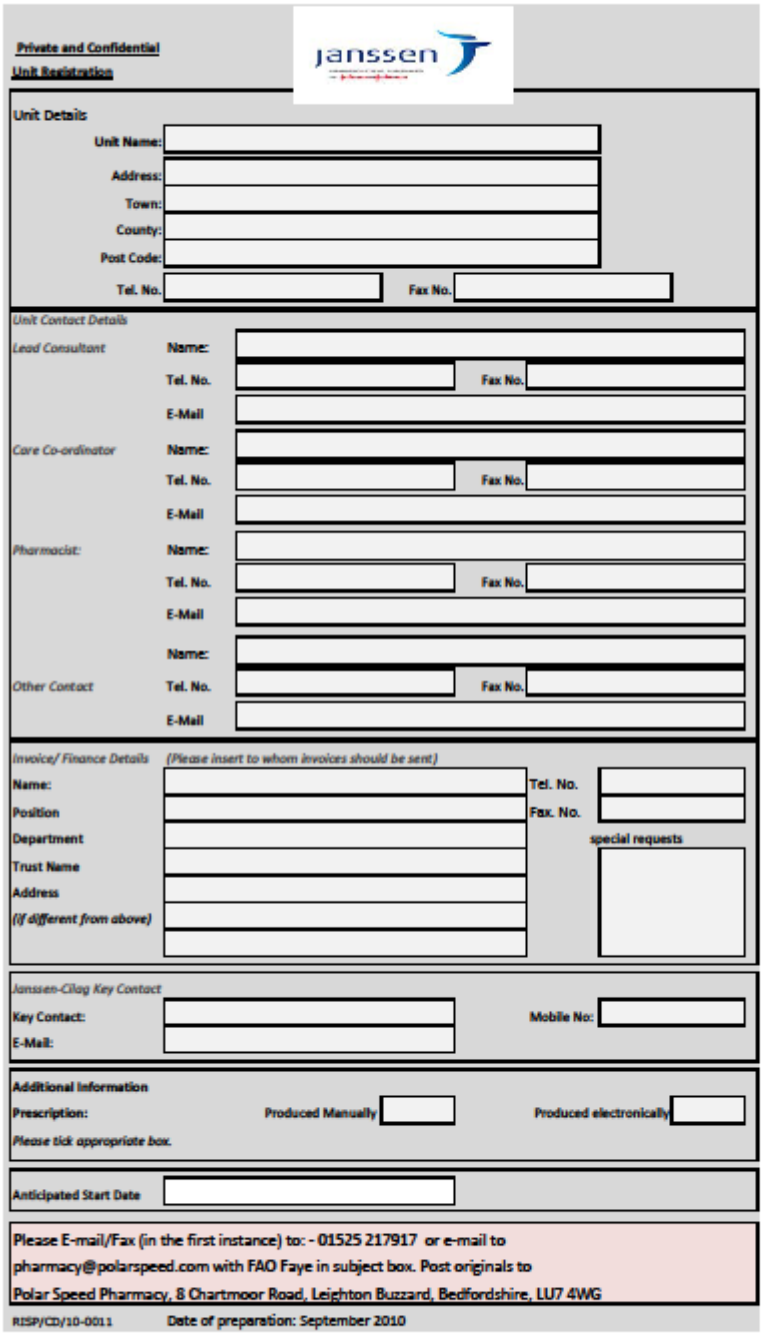
Appendix F

Polarspeed Documents

(Note: Polarspeed prescriptions are duplicate forms so cannot be reprinted here – please obtain from Polarspeed)







Private and Confidential

Unit Registration

janssen

Unit Details

Unit Name:

Address:

Town:

County:

Post Code:

Tel. No. Fax No.

Unit Contact Details

Lead Consultant Name:

Tel. No. Fax No.

E-Mail

Care Co-ordinator Name:

Tel. No. Fax No.

E-Mail

Pharmacist: Name:

Tel. No. Fax No.

E-Mail

Name:

Other Contact Tel. No. Fax No.

E-Mail

Invoice/ Finance Details *(Please insert to whom invoices should be sent)*

Name: Tel. No.

Position Fax. No.

Department special requests

Trust Name

Address

(if different from above)

Janssen-Cilag Key Contact

Key Contact: Mobile No:

E-Mail:

Additional Information

Prescription: Produced Manually Produced electronically

Please tick appropriate box.

Anticipated Start Date

Please E-mail/Fax (in the first instance) to: - 01525 217917 or e-mail to pharmacy@polarspeed.com with FAO Faye in subject box. Post originals to Polar Speed Pharmacy, 8 Chartmoor Road, Leighton Buzzard, Bedfordshire, LU7 4WG

RISP/CD/10-0011 Date of preparation: September 2010

Private and Confidential

janssen

Patient Registration Form

Patient Details

Name:		Title	
Home Address:		Delivery Address:	
Street:		Street:	
Town:		Town:	
County:		County:	
Post Code:		Post Code:	
Tel Number:		Alt. Tel Number	
		E-mail:	
Date Of Birth:		Sex (M/F):	
Allergies / Other relevant information:			

Prescriber Details

	Consultant		CPN
Name:		Name:	
Tel. Number		Tel. Number	
Address:		Address:	
Street:		Street:	
Town:		Town:	
County:		County:	
Post Code:		Post Code:	

Trust Contact Details

Pharmacist:		Tel.	
email.		Fax	
Finance		Tel.	
email.		Fax	
Other admin		Tel.	
email.		Fax	

Please register the above patient on the Janssen-Cilag service programme

Service Start date	
Signed	
Designation	
Date	

Please fax (01525 217917) and then post originals to :-
Polar Speed Pharmacy, 8 Chartmoor Road, Leighton Buzzard, Bedfordhire, LU7 4WG

RISP/C/09-0283 Date of preparation: September 2010

Patient Change of Status Form

Private and Confidential

Unit Name		Polarspeed Reference No.	
Patient Name		Title: Mr/Mrs/Ms/Miss/Other	
Patient existing Postcode:		Patient Date of Birth	

Change of Patient Status

Deceased		Moved	
Suspended		Where to?	

CHANGE OF ADDRESS? Yes/No ____ If yes, please insert new address(es) below

Home Address		Delivery Address	
Street 1		Street 1	
Street 2		Street 2	
Town		Town	
County		County	
Postcode		Postcode	
Telephone		Telephone	

Please amend the above details on the  home delivery scheme

Change Date	
Signed	
Date	

Please fax (in the first instance) to : 01525 217917 and then post originals to:
Polarspeed Pharmacy, 8 Chartmoor Road, Leighton Buzzard, Bedfordshire, LU7 4WG

RISP/C/09-0286 Date of preparation: September 2010

Appendix G

Depot Medication Administration Audit Tool

Audit to be carried out by appropriate manager at least annually.

Ref	Standard	Met (Y)	Not Met (N)	If Standard not met, please note why not. (If not, why not)
1.	The administering nurse was the regular named nurse/care co-ordinator and was a regular member of Trust staff.			
2.	Service user had received relevant information about depot, prior to administration. (Check clinical notes).			
3.	Consent to treatment had been given/was in evidence in clinical notes.			
4.	The prescription was written on the Depot Neuroleptic Card, which contained service user's personal details, including patient record number.			
5.	The Depot prescription is current (has been reviewed in the last 12 weeks)			
6.	The Depot Medication is prescribed within the standard recommended interval and dosage range.			
7.	The depot was administered in a venue of the service user's choice (check notes/ask care co-ordinator).			
8.	The following were checked by the administering nurse prior to giving the depot (check notes/ask care co-ordinator) □ any evidence of side effects from medication □ Concurrent medication □ Whether a consultation with the doctor needs to be arranged			
Complete if medication refused or withheld in audit period				
9.	If the medication was refused or with held, this information is recorded on card and in clinical notes.			

10.	The care co-ordinator and prescribing doctor and as appropriate GP were informed within 24 working hours if the medication was refused or with held (evidence via notes).			
11.	Details of action taken, by whom and when in the event of medication being refused or with held was recorded in notes.			
Complete if inpatient stay during audit period.				
12.	If an inpatient prescription sheet is/was in use, the Depot has been correctly transcribed into the Depot section of the chart and the name of the depot included in the regular section of the chart.			

Name/Designation of Auditor Date of Audit

Area Audited: Period of audit: From……..
to:……..

Appendix H

Notes on raised prolactin

Please also refer to the Guidance for Measurement of Prolactin in the Plymouth Area Joint Formulary:
http://www.plymouthformulary.nhs.uk/includes/documents/Appendix-8-Guidance-for-the-measurement-of-Prolactin-in-Patients-Receiving-Antipsychotics.pdf

1. The hyperprolactinaemia may not be due to medication. Taking a full sexual/menstrual history may determine this.

2. If the patient is currently taking oral risperidone the raised prolactin is likely to continue on risperidone long acting injection.

3. If the patient is currently taking another antipsychotic (oral or depot) the prolactin levels may change with risperidone long acting injection

4. Consider monitoring prolactin levels in line with e.g. Maudsley Prescribing Guidelines 11th ed. (p.124-5)

5. Other drugs that can cause hyperprolactinaemia are SSRIs, tricyclic antidepressants, anti-emetics, oestrogens, opiates, methyldopa, reserpine, verapamil and alprazolam.

6. Consider other causes of hyperprolactinaemia, e.g:
   Pregnancy, lactation
   Stress
   Prolactin-secreting tumour
   Hypothyroidism
   Chronic renal insufficiency
   Liver disease
   Polycystic Ovary Syndrome

7. Hyperprolactinaemia is often asymptomatic. However, adverse effects may occur including menstrual disturbances, galactorrhoea, gynacomastia, sexual dysfunction, infertility, obesity, hirsutism.

8. There may be an increased risk of osteoporosis and breast cancer. Consider other significant risk factors when deciding whether to continue with treatment:
    Personal or family history of osteoporosis
    Personal or family history of breast cancer
    Smoking
    Poor diet
    Lack of exercise
    Elderly
    Prolonged amenorrhoea in females (other than due to pregnancy)
    Hypogonadal males

    If there are significant risk factors for osteoporosis consider a Bone Density Scan.

9. Amantadine or bromocriptine may reduce prolactin levels but my also worsen psychosis. If used, evaluate the efficacy of treatment over at least one month – prolactin levels may fall within days but adverse effects such as gynocomastia respond more slowly.

10. When an oral antipsychotic is discontinued, prolactin levels fall to normal within days to weeks but adverse effects respond more slowly. With depot antipsychotics it may take up to six months for levels and adverse effects to normalise.

11. It is important to counsel female patients about the increased risk of pregnancy when prolactin levels fall.

All policies are required to be electronically signed by the Lead Director **(the policy will not be accepted onto Healthnet until the e-signature is received).**

The proof of signature for all policies is stored in the policies database.

The Lead Director approves this document and any attached appendices.

Signed:

Title: Interim Medical Director

Date: 8 March 2013