Safety Guidance: Antipsychotic Depot injections on Admission to an Acute Hospital Ward

Key Points - Summary

For all patients admitted to an Acute hospital who are on an antipsychotic depot:

CONTACT ACUTE PSYCHIATRY LIASION TO ENSURE THAT THE TEAM IS AWARE OF THE ADMISSION

- **REVIEW** the information recorded in the patient's GP records – N.B. some patients will have their depot recorded on the GP system but others will not. If the patient has procyclidine (or other anticholinergic drug) on their repeat prescription, but no antipsychotic, this may indicate that they are receiving a depot from elsewhere.
- **CHECK** with any patient with a mental health diagnosis as to what treatment they are on – prompting them to include any injections they get at home or in clinic.
- **ASK** the patient if they have a care co-ordinator and if they have their contact details.
- **CONTACT** the patient's mental health provider or community mental health liaison for further information. You need to confirm when the last dose was given, what the frequency of administration is and which site was last used. If there have been any missed doses, discuss with the patient's mental health provider. The patient's community mental health team should hold all of this information on the patient's paper depot card and within TEWV's electronic care record. The local liaison psychiatry team will have access to the patient's mental health record.
- **PRESCRIBE** the drug, formulation, dose and frequency of depot injection taken by the patient on admission.
- **CONSIDER** drugs that have been prescribed on admission – if any oral antipsychotics have been prescribed the total dose of antipsychotic needs to be considered.
- **REPEAT** all relevant tests such as U&Es, ECG, blood pressure and refer to the SPC for the depot for ongoing monitoring needs.
- **MONITOR** ongoing as per SPC – which may include BP, ECG, temperature.
- **ADMINISTER** – the depot will be administered as per local arrangements – this may be by the patient's CPN (community psychiatric nurse) or by another qualified nurse who is confident in the administration of depot injections. Depot injections are always given via the IM route.
- **RECORD** – ensure that the administration is recorded in the patient's clinical notes at the acute Trust and by their usual mental health provider. Document the administration on any discharge or transfer paperwork.

Issue	The purpose of this "Safety Guidance" is to highlight key issues to be considered when patients on antipsychotic depot injections are admitted to an Acute hospital. Antipsychotic depot injections are a high risk group of drugs requiring regular monitoring and specific administration.
Assessment on Admission and Prescribing of Antipsychotic depot Therapy	**For all patients admitted to an acute hospital who are taking an antipsychotic depot therapy:** **REVIEW** the information gathered about their depot injection, relating to prescribed drug, dose formulation and monitoring. **CHECK** the patient's ECG, blood values and blood pressure. **AVOID -Signs of any adverse effects which may contraindicate the administration of the depot - such as neuroleptic malignant syndrome (NMS) - should be monitored for. These include fever, rigidity, confusion, fluctuating level of consciousness, fluctuating BP, tachycardia, elevated CK and altered LFTs.** **PRESCRIBE** the antipsychotic depot injection by drug name – taking care to prescribe the correct drug as there are some antipsychotics with similar names. The route will be IM. ***The safest way to ensure continuity of drug is usually to use the patient's own medication. Alternatively, contact the patient's CPN for advice.*** Information specifying the brand and formulation must be: • Recorded on the ePMA system or paper drug chart for in-patient administration, on discharge, on FP10 prescriptions and where these are referenced in any letters and medical notes. • Included in the Medicines Reconciliation / Medication History Section of the medical notes

	CONSIDER the prescription of other antipsychotic drugs orally – the percentage of BNF maximum dose should be added to the percentage of BNF maximum of the depot injection. Additional monitoring is required if this total goes over 100% - this is classed as high dose antipsychotic therapy (HDAT). The local mental health Trust or liaison will be able to give advice on this.

Monitoring of antipsychotic depot injections	**Monitoring of antipsychotic depot injections.**
	Baseline, 3 months after initiation, and annually.
	
	Weight (Waist measurement and BMI where possible)**.** Antipsychotic drugs can cause weight gain and this can contribute to an ↑ risk of cardiovascular and metabolic problems.
	Lipids (Total cholesterol, HDL cholesterol, Total/ HDH-cholesterol ratio, Triglycerides - fasting sample if possible). Some antipsychotics can cause small adverse changes in lipid profiles. Triglyceride levels can rise during periods of weight gain.
	Blood Glucose FBG/HbA1c. Antipsychotics can increase the risk of developing diabetes.
	Blood Pressure (sitting / lying and standing) and pulse. Hypotension is a side effect of many antipsychotics and it is important to monitor this during periods of initiation and stabilisation. Longer term it is important to monitor and manage factors that influence a patient's CV risk. Monitoring should be done at baseline, after 12 weeks, annually, and frequently during dose titration, as determined by clinical situation.
	Prolactin Antipsychotics can increase prolactin levels. This can inhibit sex hormones – oestrogen and testosterone and may ↑ risk of osteoporosis. In certain groups such as some elderly patients, this may not be necessary- judge on clinical need.
	ECG (QTc Interval). Many antipsychotics are associated with ECG changes and some are linked to prolongation of the QT interval. All new inpatients should have an ECG on admission. For long stay patients and those in the community, when clinically indicated, ECGs should be performed at baseline and annually. Factors that may determine if ECG monitoring is clinically indicated include:
	• If there is a personal history of cardiovascular disease (e.g. known ischaemic / structural heart disease QT prolongation)
	• If physical examination identifies cardiovascular risk factors
	• If patients on antipsychotics that require ECG monitoring e.g. haloperidol or pimozide (check summary of product characteristics for more information)
	• If a patient is on high dose antipsychotic therapy (HDAT)
	• If patient is on other drugs known to cause ECG abnormalities (e.g. Tricyclic antidepressants, erythromycin, antiarrhythmics – see BNF for further information)
	• If the patient has Factors which may predispose to arrhythmias including:
	  ○ Electrolyte abnormalities – hypokalaemia, hypocalcaemia, hypomagnesaemia
	  ○ Systemic disease – liver disease, renal disease, hypothyroidism
	Baseline and annually.
	Urea and electrolytes, (including creatinine or estimated GFR). Patients with renal impairment may have reduced capacity to excrete drugs and dose reductions may be required. Hypokalaemia is linked to QTc lengthening and other ECG abnormalities.
	Liver function (Bilirubin, Alk Phos, ALT, Albumin, Total protein, Gamma-GT). Patients with hepatic impairment may have reduced capacity to metabolise drugs and dose reductions may be required. Drug induced liver damage can be due to direct dose related hepatotoxicity or hypersensitivity reactions. Risk factors for drug induced hepatotoxicity include - ↑age, female gender, alcohol, prescribed enzyme inducing drugs, obesity.
	Full Blood Count (Hb, WBC, Platelets). BNF advises caution when using antipsychotics in patients with blood dyscrasias. Antipsychotics can cause blood dyscrasias including agranulocytosis and leucopenia.
	As appropriate- e.g. on admission/review
	Pregnancy test If there is any uncertainty about the possibility of pregnancy, a urine pregnancy test should be carried out.
	Smoking status. Linked to CV risk.
	Drug screening. If indicated by history or clinical picture.

	Review of the side effects of drug treatment, efficacy and adherence. Before treatment, the side effects the patient is least willing to tolerate should be assessed. On review, the treatment efficacy, patient adherence and side effects experienced should be assessed. Side effects may include: • Extrapyramidal symptoms, akathisia, dystonia and tardive dyskinesia • Common side effects e.g. sedation • Less common but serious adverse effects e.g. palpitations. An appropriate rating scale may be useful (e.g. GASS) **Action** Any results deemed abnormal should be discussed within the medical team and discussed with the mental health team if necessary. Before any decisions are made to alter the dose/stop a mental health drug, the mental health professional looking after the patient should be contacted for further advice.
Action for Nurses & Midwives	**ADMINISTER – there is no reason why a depot injection cannot be safely administered by a registered nurse in an acute trust.** Dependent upon local arrangements, the patient's CPN may be able to administer the specified antipsychotic depot injection. If no dose or frequency is specified, then every effort should be made to clarify before administration is due and it should not administered until the depot is prescribed correctly. Note - some depot injections have specific administration directions. All are given IM. If the CPN is not involved in the administration then refer to the patient's community mental health team for advice or follow the local agreed arrangements. Ensure that the administration is documented in all relevant patient clinical notes and on any discharge or transfer documentation.

Action for Pharmacy Staff	• Pharmacy staff must try to ascertain the details required for accurate prescribing such as the exact drug name, dose, frequency of dose and date and site of last dose. This information should be included in the Medicines Reconciliation / Medication History Section of the medical notes where pharmacy is supporting this process.
	• Appropriate supply – ensure supply via one of the following options:
	  ○ Use of patient's own drug
	  ○ Supply provided via CPN
	  ○ Supply through temporary stock order from Acute Trust dispensary

Commonly asked question	• Depot is late- can I still give it? Staff must make every effort to administer depot / LAI's on the prescribed due date. If they are unable to do this due to circumstances beyond their control, then there is a tolerance table available within TEWV's inpatient and community depot procedures. Different depots have different allowed windows within which they can be administered dependent upon the frequency of the usual administration. A discussion would be required with the prescriber and TEWV pharmacy team.
Contact Details	The patient should have direct contact details of the mental health clinical team responsible for their care. If these details are not available, the TEWV community team contact details can be accessed by calling the appropriate pharmacy team. **Durham pharmacy office – 0191 4415775, Darlington pharmacy office – 01325 552105, Roseberry Park pharmacy office – 01642 838360, York pharmacy office - 0190 4717790.** **Liaison may be able to offer advice. For Durham and Darlington only - Samantha Moore, Liaison and Integrated Urgent Care - Pharmacist - 07584006945. For other areas, acute hospital liaison can be contacted via the Trust Switchboard.** **The TEWV on call pharmacist can be contacted via the hospital switchboard out of hours. TEWV Switchboard: 01642 838050.**
Further Information	For further information please see – North-of-England-guidance-for-long-acting-antipsychotic-injections-July-17.pdf (tewv.nhs.uk)