AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for healthcare services

Psychotropic Medicines in Cognitive Disability or Impairment

Clinical Care Standard

The *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard* aims to ensure the safe and appropriate use of psychotropic medicines in people with cognitive disability or impairment and to uphold their rights, dignity, health and quality of life.

The *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard* contains eight quality statements that describe the health care that people of all ages with cognitive disability or impairment should receive to optimise the prescribing and use of psychotropic medicines when they are prescribed in response to behaviours of concern, or for treating a mental health condition.

It can be applied in all settings where people living with cognitive disability or impairment receive health care.

A set of indicators is provided to support healthcare services to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities. The definitions required to collect and calculate indicator data are specified online at **meteor.aihw.gov.au/content/791005**.

Monitoring the implementation of this clinical care standard will help healthcare services to meet the requirements of:

- The National Safety and Quality Health Service (NSQHS) Standards for acute healthcare services
- The National Safety and Quality Primary and Community Healthcare (Primary and Community Healthcare) Standards, for participating primary healthcare services.

1 Person-centred care

A person receives health care that is driven by their individual preferences, needs and values, and that upholds their personal dignity, human rights and legal rights. The person is supported to be an active participant in making informed choices about their care, together with their family, support people or nominated decision-maker as appropriate.

Ensure that policies and procedures are in place to support healthcare providers to deliver person-centred care to people with cognitive disability and impairment. These should ensure that:

- Information and resources, such as shared decision-making tools, are available to meet diverse health literacy, medicines literacy, communication and cultural needs
- The person's family, support people or nominated decision-maker have been identified and documented in the healthcare record
- The person and their appropriate family, support people or nominated decision-maker are provided with information about their care

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- The person and their appropriate family and support people are involved in decisions about their care to the greatest extent possible or to the extent that they choose (for example, if a person does not have capacity for decision-making, they are still consulted to the greatest extent possible, by those who will make the decision)
- Reasonable adjustments are identified and implemented to facilitate the person's active participation in decision-making, including support to enable a person with capacity to make a decision, and support to increase participation by those without capacity.

Ensure adequate skills and competence in the workforce by:

- Providing rights-based training and communication skills training to relevant members of the workforce
- Providing members of the workforce with training on capacity assessments
- Providing members of the workforce with training on techniques to support participation in decision-making by people with cognitive disability or impairment.

Indicator for local monitoring

There is no indicator for this quality statement.

2 Informed consent for psychotropic medicines

If psychotropic medicines are being considered, the person – and their family, support people or nominated decision-maker as appropriate – is informed about the reason, intended duration, and potential benefits and harms of treatment. If use of a psychotropic medicine is agreed, informed consent is documented before use. In an emergency, or if the person does not have capacity to make a decision even with support, processes are followed in accordance with relevant legislation.

Ensure that policies and procedures outline requirements for providing psychotropic medicines information and obtaining and documenting informed consent.

Ensure that systems are in place for healthcare providers to provide information about psychotropic medicines and discuss their use with the person, and family members, support people and nominated decision-makers as appropriate. To enable informed decision-making, these discussions should include a description of the risks and benefits of taking or not taking psychotropic medicines.

Ensure that policies and procedures enable the person, family members and support people to receive information in ways they can understand and to have an opportunity to ask questions before consent is sought. Ensure policies and procedures support a person's rights to make decisions and include the use of reasonable adjustments in line with the person's needs. These should help the person, family members and support people to participate more effectively in decision-making about their treatment, consistent with the NSQHS Partnering with Consumers Standard.

If a person needs supports and adjustments to enhance their participation in decision-making, ensure that information about the types of support required is documented and accessible in clinical communications to all relevant healthcare providers. This is especially important when care is provided by a multidisciplinary team, and when a person is transferred or referred to another healthcare setting or healthcare provider. Processes for seeking informed consent should consider that the person's capacity may fluctuate, and capacity should be reviewed periodically to ensure that consent remains valid. Ensure policies and procedures are consistent with relevant guidelines and legislation for assessing capacity and seeking informed consent and for exemptions in emergency situations.

Indicator for local monitoring

Indicator 2a: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine for whom informed consent was obtained and documented.

3 Assessing behaviours

A person with behaviours of concern is initially assessed for immediate risks to their safety and others. Further assessment is undertaken to identify clinical, psychosocial and environmental causes of the behaviours, and to understand the context in which they occur. Assessment is carried out by suitably trained individuals, and considers existing plans to support the person's care and information from others who know the person well.

Ensure that systems are in place for healthcare providers to safely carry out a comprehensive assessment for people with behaviours of concern, and to document results in the person's healthcare record. Such assessment should consider the behaviour's context and its clinical, psychosocial and environmental causes. Clinical assessment should also include assessment for **delirium**. Ensure that policies and procedures support reasonable adjustments for people with cognitive disability or impairment to facilitate their assessment. This may include:

- Involving family members and support people in the assessment with the person's consent, and involving nominated decision-makers as appropriate. This may include allowing access for family, support people and nominated decision-makers to the health care service outside regular visiting hours
- Considering the environment in which the assessment takes place and allowing for modifications to provide safe and supportive care (for example, moving the person to a quieter room)
- Referring to any care plans that document existing behaviours and management strategies, such as advanced care plans or behaviour support plans (required for recipients of aged care services and some recipients of the National Disability Insurance Scheme [NDIS] services).

Ensure that any records of legal nominated decision-makers, guardianship or administration orders are kept in an easily accessed place. Ensure all members of the workforce who care for the person are aware of these arrangements.

Train and educate the workforce about the potential causes of behaviours in people with cognitive disability or impairment, including in relation to trauma-informed care. Ensure that all those involved in providing care are aware of the role of care plans, including behaviour support plans required for the person under aged care or NDIS regulations for recipients of these services. Support referral to suitably trained providers if required to assess behaviours and contributing psychosocial or environmental factors.

Indicator for local monitoring

Indicator 3a: Evidence of local arrangements to ensure a person with cognitive disability or impairment with behaviours of concern is assessed to identify any clinical, psychosocial and environmental causes for the behaviours.

The local arrangements should specify the:

- Procedures to support reasonable adjustments for a person with cognitive disability or impairment to facilitate their involvement in the assessment process
- Process to access any existing care or behaviour support plans
- Process to involve the person's family or support people, in accordance with the person's wishes, and nominated decision-makers as appropriate
- Process to ensure any records of legal nominated decision-makers, guardianship or administration orders are accessible to staff
- Process to ensure relevant clinicians and members of the workforce receive training and education about the potential causes of behaviours in people with cognitive disability or impairment, including how to provide trauma-informed care
- Findings of assessments that should be documented in the person's healthcare record
- Process to oversee implementation of the local arrangements and evaluate their effectiveness.

4 Non-medication strategies

Non-medication strategies are used first-line and as the mainstay of care when responding to behaviours of concern. The choice of strategies is individualised to the person and is documented and communicated to all those involved in their care.

Ensure that systems, processes and resources are in place for the multidisciplinary team to offer and use appropriate non-medication strategies in response to behaviours of concern both first-line and as part of ongoing care.

Establish appropriate leadership and governance for oversight of these systems.

Ensure each member of the workforce is trained and competent in the use of non-medication strategies – appropriate to their role and scope of practice – that could be implemented for a person with behaviours of concern. This may involve identifying specialist clinicians or lead clinicians at a healthcare service level to train the workforce in the use of de-escalation techniques and other non-medication strategies.

Provide systems to support documentation of the non-medication strategies that are recommended and used for the person, and to embed strategies that are effective for the person into their care. Enable members of the workforce to implement environmental changes when appropriate, such as lighting, noise, signage (for example, toilet locations), privacy or access to outdoor space.

Policies should incorporate use of the person's regulated aged care or NDIS behaviour support plan and take into account the information provided in the plan, as well as any information provided by the person's family, support people or care provider.

Indicator for local monitoring

Indicator 4a: Evidence of local arrangements to ensure people with cognitive disability or impairment receive appropriate non-medication strategies to prevent or reduce behaviours of concern.

The arrangements should specify the process to:

- Select and implement appropriate non-medication strategies, based on a person's assessment
- Monitor and document a person's response to the non-medication strategies
- Ensure clinicians and other members of the workforce who are involved in the care of people with cognitive disability or impairment receive education and training on non-medication strategies to prevent or reduce behaviours of concern, appropriate to their role and scope of practice
- Inform clinicians and other members of the workforce about the non-medication strategies that can be implemented at the service
- Oversee implementation of the local arrangements and evaluate their effectiveness.

5 Behaviour support plans

If a person has a plan to support their behaviour, it is used to inform and support their care. The person's response to care provided under the plan – including any use of psychotropic medicines – is continually assessed, documented and communicated to inform regular updates to the plan and prescribing decisions.

Healthcare services that provide care to people with cognitive disability or impairment who have an existing behaviour support plan should:

- Provide guidance and protocols to ensure the behaviour support needs outlined in the person's behaviour support plan are recognised and responded to during their care, which can prevent escalation of behaviours and reduce the need to use restrictive practices such as psychotropic medicines

- Ensure that acknowledgement and use of the person's behaviour support plan and relevant feedback about the person's response are included in the person's healthcare record and correspondence, and that this is shared appropriately with other providers of care and support
- Establish relationships with local aged care and disability coordinators or case managers who can assist in escalation of plan reviews or provide other expert advice when required.

Healthcare services that are responsible for ensuring that a behaviour support plan is developed should:

- Ensure that behaviour support plans are clear and concise so they are easy to use by the person, their family, support people and healthcare providers
- Ensure that behaviour support plans consider feedback provided by other healthcare providers about the person, including further behaviour support needs that may arise in healthcare settings, such as during hospitalisation
- Refer to guidelines for developing behaviour support plans provided by the NDIS Quality and Safeguards Commission or Aged Care Quality and Safety Commission, as relevant.

Indicator for local monitoring

Indicator 5a: Evidence of a local policy to ensure a person's behaviour support plan is used to support their care.

The policy should specify the:

- Protocol to identify people who have an existing behaviour support plan
- Process to communicate with aged care and disability service providers to request a copy of a person's behaviour support plan if it is not available when they present to hospital
- Process to support clinicians to consider a person's behaviour support plan when providing health care to the person
- Process to support clinicians to document the person's response to the behaviour support plan and any recommendations to inform updates to the plan
- Process to assess adherence to the policy.

6 Appropriate reasons for prescribing psychotropic medicines

Psychotropic medicines are considered in response to behaviours only when there is a significant risk of harm to the person or others, or when the behaviours have a major impact on the person's quality of life and a reasonable trial of non-medication strategies has been ineffective. Psychotropic medicines are also considered when a mental health condition has been diagnosed or is reasonably suspected following a documented clinical assessment. The reason for use is clearly documented in the person's healthcare record at the time of prescribing.

Ensure policies outline the safe and appropriate use of psychotropic medicines and the steps that should be followed prior to prescribing. For emergency, short-term and ongoing use, including PRN, this includes assessing whether appropriate non-medication strategies have been systematically trialled for a reasonable period of time, according to the reason for use (for example, whether the medicine was used in an emergency or in a less acute context).

Ensure documentation of the reason for prescribing for any psychotropic medicine, including for medicines prescribed PRN, regardless of the indication or therapeutic use. This includes documenting the diagnosis or, in the case of a suspected mental health diagnosis in a non-verbal person, the clinical assessment conducted and the expected effect of the medicines.

Ensure that all medication charts including electronic charts include indications for use of psychotropic medicines. If medicines are used PRN, ensure documentation about use – as well as the behaviours observed when prescribed for behaviours of concern – is available to facilitate a fully informed review of the medicines' effectiveness.

Establish processes to audit the appropriateness of any psychotropic medicine prescribing, including medicines prescribed PRN. Auditing processes should include evidence of the clinical assessment and rationale for prescribing. In the context of behaviours of concern, this should include auditing evidence of an inadequate response to non-medication strategies prior to prescribing psychotropic medicines.

Indicators for local monitoring

Indicator 6a: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine for whom the reason(s) for prescribing the medicine was documented in their healthcare record.

Indicator 6b: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine for behaviours of concern who had a comprehensive assessment to identify factors that might be contributing to the behaviours.

Indicator 6c: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine for behaviours of concern who were also receiving non-medication strategies.

7 Monitoring, reviewing and ceasing psychotropic medicines

A person's response to psychotropic medicines is regularly monitored and reviewed according to the person's individual needs and goals of treatment. The benefits and harms of treatment, and the potential for dose adjustment or cessation are considered at each review. The outcome is documented and communicated, along with the timing of the next review.

Establish processes to ensure a quality use of medicines approach to the monitoring and review of psychotropic medicines.

Ensure policies and procedures are in place to outline the processes for monitoring and reviewing a person's medicines, including:

- Identifying monitoring requirements according to individual needs, and how these will be documented
- Identifying the most appropriate healthcare providers responsible for conducting a medication review
- Documenting the timing of the next review, in line with the person's individual needs and the goals of treatment
- Documenting and communicating actions and recommendations to ensure they are accessible to all those involved in a person's care (for example, the use of paper-based or electronic forms)
- Engaging with family, support people and support workers when reviewing a person's medicines and seeking feedback about changes in the person's behaviour
- Ensuring the results of a review are discussed with the person and, if appropriate, parents, family, support people, support workers and other relevant people, including the person's general practitioner or other regular prescriber
- Identifying and prioritising for review people who are most at risk of, or have experienced, medicines-related harm
- Monitoring the duration of psychotropic medicines use, the appropriateness of review intervals and trends in medicine-related harms identified during a review, which could also include harms that have been prevented.

Access Australian Government–funded medication review programs, such as Home Medicines Review or Residential Medication Management Review, if relevant.

Services responsible for the behaviour support plan should ensure those who developed it are regularly reviewing the person to ensure that the planned support strategies are in place and their usefulness is assessed when the dose of a psychotropic medicine is modified or being ceased, and reviewing the plan with regard to the person's needs.

Indicators for local monitoring

Indicator 7a: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine for whom the timeframe to review the medicine was documented in their healthcare record.

Indicator 7b: Proportion of people with cognitive disability or impairment who were prescribed a psychotropic medicine for whom the effectiveness of the medicine on target symptoms and any adverse effects were documented at each review.

8 Information sharing and communication at transitions of care

When the health care of a person is transferred, information about their ongoing needs is shared with the person, their family or support people and the healthcare and service providers continuing their care. This includes information about behaviour support plans or other strategies. If psychotropic medicines are prescribed, the reason for use, intended duration, timing of last administration, and plans for monitoring and review are documented and communicated to support the person's ongoing care.

Ensure that systems, policies and procedures are in place that support healthcare providers to effectively communicate comprehensive, accurate and up-to-date information about a person's ongoing care when a transition of care occurs. This communication should include any medicine-related needs and any risks to the person's behaviour that may arise with the transition of care.

Ensure policies and procedures:

- Include the need to transfer documentation about strategies known to be effective in supporting a person's behaviour, which may avoid the use of psychotropic medicines; for example, the person's behaviour support plan, if they have one, or documentation in the discharge summary
- Include the requirement for a current medicines list to be transferred to enable continuity of medicines management
- Outline expectations about the timeframe in which communication should occur – emphasising that timely communication is critical to the relevance of the information – and what to do if information is not received.

If psychotropic medicines are prescribed for behaviours of concern, ensure documentation is transferred with the person, outlining:

- Behaviours that have been observed
- Causes for the behaviour observed
- Non-medication strategies that were tried or used
- Reason for prescribing the psychotropic medicine
- Effectiveness of the medicine on the target symptoms
- Potential adverse effects that may affect their care plan (such as falls risk)
- Ongoing monitoring requirements
- Plans for review or discontinuation of the medicine.

In acute healthcare services, implement the relevant NSQHS Standards and refer to the **Guiding principles to achieve continuity in medication management** to support best practice and safe and quality use of medicines at transitions of care.

With the person's consent, information should be transferred securely, for example, through a secure messaging system, on paper, or by uploading to digital systems such as the person's My Health Record. This provides other clinicians with access to details about the person's care and their medicines, which can be vital for informing ongoing care in the community. Sharing information about the care provided in all care settings is especially important if the person transitions to interim care (rehabilitation or respite care) before returning to their usual residence and healthcare provider. Ensure the transfer of information takes into account consent requirements and the person's right to privacy and confidentiality.

Aged care homes may need to use additional documentation to support the safe and quality use of medicines at transitions of care. Examples include the Interim Residential Medication Administration Chart or the **Aged Care Transfer-to-Hospital Envelope**.

Indicators for local monitoring

Indicator 8a: Evidence of a locally approved policy to ensure that information about a person's behaviour support needs and their psychotropic medicines is transferred with the person between care settings.

The policy should specify the:

- Behaviour support information, including the person's behaviour support plan if they have one, that is to be transferred with the person between care settings
- Healthcare information, including a complete and accurate medicines list and key details about the use of any psychotropic medicines, that is to be transferred with the person between care settings
- Requirement to maintain and transfer up-to-date contact details of the person's family members, support people or nominated decision-maker and, as relevant, the person's disability service providers, general practitioner, Aboriginal and Torres Strait Islander Health and Medical Service, and other care and service providers
- Process to ensure the information is transferred with the person between care settings
- Process to ensure the workforce is informed and competent in the use of the policy.

Indicator 8b: Proportion of people with cognitive disability or impairment discharged with a supply or prescription for psychotropic medicine where the person or support people were provided with information about the medicine on discharge.

Indicators for local monitoring

Indicator 8c: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine while in hospital, whose discharge information was sent to the clinician responsible for their care on discharge.

Indicator 8d: Proportion of people with cognitive disability or impairment who were prescribed psychotropic medicine while in hospital, whose discharge information was sent to their aged care or disability service provider on discharge.

Questions?

Further information about the *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard* and other resources is available from: **www.safetyandquality.gov.au/psychotropics-ccs**.

You can also contact the Clinical Care Standards program team at: **ccs@safetyandquality.gov.au**.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.