Administration of depot and long-acting antipsychotic injections

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It is essential for healthcare professionals to share good practice and information in partnership with those who use health and social care services (National Institute for Mental Health in England 2008). The aim of this guide is to inform all practitioners, managers, service users and carers about the use of intramuscular (IM) depot and long-acting injectable (LAI) antipsychotic medication. The recognition of service users’ need for privacy, safety and dignity when receiving these injections will be emphasised.

Fourteen years ago Good Practice in the Administration of Depot Injections (Royal College of Nursing (RCN) 1994) failed to mention the humane aspects of the procedure of administering injections in terms of privacy, dignity and the environment. However, important issues of dissatisfaction with the experience of receiving injections were highlighted by service users (RCN 1994):

› The reason for having an injection had not been explained.
› They were receiving too much medication.
› They received too little information on side effects.

The group responsible for writing this guide in 2008, aware of the development of more meaningful service user/patient and carer involvement, reviewed a large number of protocols, guides and procedures from across the UK. Findings showed that the majority focused on technical aspects and generally omitted the importance of the relationship between the healthcare professional and the service user. A recent publication highlighted good practice in the technical administration of all IM injections, but did not address important differences in the administration of depot or LAI antipsychotics (Hunter 2008).

In support of the principle of incorporating the recovery approach into every aspect of mental health nursing practice (Department of Health (DH) 2006a), this guide emphasises the importance of a partnership between the healthcare professional and service users, using technical information to illustrate, educate and encourage good practice. The working group has considered the principles of working within a recovery framework, the environment, working in partnership, informed choice, pharmacology, technique, monitoring and maintaining competence and knowledge. In each section the reader is signposted to a number of useful publications and good practice points are highlighted.

Please note: where possible the term service user has been adopted; the term patient has been used interchangeably where it seemed appropriate or when it is citing a direct reference. 

Cartoons The cartoons featured throughout this guide (© Andrew Voyce 2008) have been created by a user of mental health services and are a representation of the reported experiences of people receiving depot injections in the 1980s. The illustrations are presented without comment; readers are encouraged to draw their own conclusions of the nursing practice depicted.

Working within a recovery approach
‘Recovery is a deeply personal unique process of changing one’s attitudes, values, feelings, goals, skill and or roles’ (Kelly and Gamble 2005).
‘Offering help, treatment and care in an
atmosphere of hope and optimism’ is the first and overarching principle in the National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment of people with schizophrenia (NICE 2002).

Recovery means different things to different people (Kelly and Gamble 2005). In mental health, the notion of recovery is not about a ‘cure of a condition of biological origin’; it is about the recovery of the whole person. A way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in life as the individual grows beyond the catastrophic effects of mental illness (Anthony 1993).

The values and principles of recovery should underpin everything we do, every word we speak to colleagues and service users, and every intervention we offer. At the core of the recovery approach is the absolute belief that there are ‘no limits’ to the potential for recovery after a diagnosis of mental illness.

The basic principles and values of the recovery approach will inform the nurse administering the depot medication to ‘work in partnership with the patient and offer meaningful choice’ (DH 2006a).

What service users and carers should expect from a service:
- That their aims are valued.
- Partnership working that offers meaningful choice.
- Optimism, hope and the possibility of positive change.
- The promotion of social inclusion.

Health and social care staff should provide (Roberts and Wolfson 2004):
- An understanding of recovery principles.
- Recognition of, and support for, the individual’s personal resources.
- An understanding of, and accommodation for, the diverse views on mental illness, treatments, services and recovery.
- Awareness and skills to communicate respectfully and develop good relationships.
- An understanding and active protection of service users’ rights.
- An understanding of discrimination and social exclusion; how these may affect lifestyle and knowledge of how they can be reduced.
- Acknowledgement of the importance of cultural beliefs and values.
- Comprehensive knowledge of community services and resources.
- Knowledge of patient groups and movements and support in accessing them.
- Knowledge of family, friends and carers’ views and a willingness to support them.

The environment of administration Service users have a right to care that actively promotes (DH 2001a):
- Privacy – freedom from intrusion.
- Dignity – being worthy of respect.

The decision on which environment is chosen to
administer the injection should be agreed between service users and clinicians involved in their care. Irrespective of the setting, and indeed who administers the injection, the good practice points in Box 1 should be followed.

Working in partnership 'It is important to note that concordance is not a new, politically correct, way of referring to compliance. Compliance measures patient behaviour: the extent to which patients take medicines according to the prescribed instructions. However, concordance measures a two-way consultation process: shared decision-making about medicines between a healthcare professional and a patient, based on partnership, where the patient's expertise and beliefs are fully valued' (National Prescribing Centre (NPC) Plus 2007).

Creating a therapeutic alliance is dependent on the attitudes, values and core communication skills of the healthcare professional. Patel et al. (2005) specifically highlight advocacy and treatment decision making for enhanced nurse-patient interactions as components of training and refresher courses. Such training will help promote the process of making shared decisions about treatment with the patient.

The act of administering a depot or LAI antipsychotic should not be seen as an isolated behaviour; it should be viewed as an important and integral part of the individual service user's whole matrix of care. While the administration of the injection is most likely to be carried out by a nurse, it would be wrong to assume that other disciplines involved in the care should be divorced from the process. Effective communication between all professionals is essential in ensuring consistent levels of care.

Gray and Robson (2005) have developed a flexible and adaptable toolkit that can be used by healthcare workers to structure conversations with service users about medication. This toolkit emphasises the service user’s rights, the need for an exchange of information and two-way

| BOX 1 |
| Good practice points |

- Maintain a therapeutic environment by valuing the nurse-patient relationship in the context of the injection-giving process.
- Create a safe and secure atmosphere through provision of dependable and consistent practitioners.
- Where possible, the same person should administer the injection on each occasion.
- Exchange information about medication and local resources.
- Create space in clinics for service users to meet and interact with each other.

(Adapted from Phillips and McCann (2007))
communication, and supports useful skills such as problem solving and decision making. Box 2 lists some useful communication skills.

**Informed choice**

Every adult must be presumed to have the mental capacity to consent to, or refuse, treatment unless they are unable to (Mental Capacity Act 2005):

- Understand the information relevant to the decision.
- Retain that information.
- Use or weigh that information as part of the process of making the decision.
- Communicate their decision by talking, using sign language or any other means.

Obtaining consent is a process rather than a one-off event (DH 2001b). The need to maintain this continual process is necessary as treatment changes and the individual's understanding and needs fluctuates. Responding to changing needs for information exchange as the patient moves along a spectrum from a place where decisions may have been made for them towards autonomy, shared decision making and informed choice is important in supporting recovery.

Healthcare professionals, patients and their carers should communicate progress along this spectrum on transfer to other teams to ensure that work can be continued and lessons learnt from each episode of care.

A meaningful exchange of information, discussion and choice depends on clear communication of the rationale for treatment, not just of the benefits and risks. This is most useful when framed in the language of the service user, rather than the language of psychiatry, for example, what the medication is expected to do for the problems experienced by the service user. NPC Plus (2007), Usher and Arthur (1997) and Rollnick *et al* (2000) suggest frameworks to guide this process in practice.

'Advanced decisions' to refuse medical treatment are legally binding if they are valid and applicable, that is – the person had consent at the time they made the decision and that the decision made is applicable to the current decision. Advanced decisions do not have to be made in writing, unless they are to refuse life-sustaining treatment (Mental Capacity Act 2005).

The law and professional bodies recognise the power of advance directives, advance statements or living wills. These are documents made in
advance of a particular condition arising and show the patient's treatment choices. While not legally binding, they can provide useful information about the wishes of a patient who is subsequently unable to make a decision. There is clearly an opportunity immediately following any relapse or crisis to work with the patient and carers to capture important information, which can inform advanced statements.

The law in relation to capacity, consent and mental health is fluid and complex. Dimond (2008) provides a comprehensive overview and includes example scenarios from mental health practice. Further good practice points are shown in Box 3.

**Pharmacology**

Although biological, social and psychological factors are all important in the maintenance of mental health, medication treatment focuses on treating chemical imbalances in the brain to minimise distressing symptoms and provide protection from relapse. Positive symptoms of psychosis are thought to be due to an excess of the neurotransmitter chemical dopamine in the synapses between brain cells in the limbic area of the brain. Cognitive symptoms and negative symptoms are thought to be related to too little dopamine in the synapses of the cerebral cortex. Mood symptoms are thought to be related to a different neurotransmitter – serotonin.

However, dopamine and serotonin levels are finely balanced, too much of one can affect the balance of the other.

Medication for psychosis is now classified into three types. The first generation, or typical

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**BOX 3**

**Good practice points**

- Consent is an ongoing process.
- Identify a rationale for the injection based on the experience of the service user and in his or her own language.
- Frameworks to guide interventions in process consent and reflect on one’s own competence are available (Usher and Arthur 1997, NPC Plus 2007).
- The Elicit-Provide-Elicit model can be used to exchange information based on needs at any one time (Rollnick et al 2000).
- Work with the service user and carer to capture information to inform future risk and relapse plans and advanced statements.
- Careful documentation and communication can promote ongoing collaboration in an informed choice process.
antipsychotics were the first to be licensed and include most injections. Second- and third-generation, or atypical antipsychotics, include products that have been licensed since clozapine.

All antipsychotic medications target dopamine receptors in the brain. In addition, antipsychotic medication can affect a range of other types of receptors including the receptors for serotonin, acetylcholine, noradrenalin (norepinephrine) and histamine as well as several other types of dopamine receptors. This action is largely responsible for side effects but can also be beneficial, for example, to aid sleep. Evidence suggests that the different products are largely equal in their ability to treat symptoms of psychosis (efficacy) but their different side effect profiles affect their acceptability, tolerability and overall effectiveness in practice (Tandon and Jibson 2003, Lieberman et al 2005, Jones et al 2006).

Long-acting antipsychotic medications by intramuscular injection Intramuscular injections of antipsychotic medications were developed to allow the medicines to be delivered in a modified way, over time, following administration. This has the advantage of promoting a steady therapeutic concentration of the drug, while minimising some of the side effects and variable effects on symptoms that may result from the peaks and troughs experienced when only tablets are taken. The achievement of a steady therapeutic level from regular injections also affords protection from relapse beyond the time the last injection was received. Specific information about each product can be found in the individual summary of product characteristics.

If lifestyle factors make regular taking of oral medication difficult, or the service user has a preference for injections rather than tablets, this can provide an important protection from stress, prevent relapse and maintain mental health in the future.

First-generation long-acting ‘depot’ antipsychotic injections First-generation antipsychotic LAIs are commonly called ‘depot’ injections. Depot refers to the way the drug is deposited and stored in the muscle before being absorbed. Manufacturers formulated these products in an oil base, which takes time to move out of the muscle into the bloodstream. The oils used include sesame and coconut and differ between products. The injections are made deep into the gluteus muscle.

Time to steady state, when optimal therapeutic dose is achieved, can take between eight and 12 weeks after first administration of the full dose. Peak concentration occurs from seven to ten days after the injection and this is when side effects are also likely to peak (Bazire 2007).

These medications take a long time to be eliminated from the body, so various benefits, and indeed side effects, can persist for some time following the last injection. This is why administration of a small test dose is recommended. A test dose also allows an assessment of any allergic response (for example to a nut oil diluent). The elimination effect should also be taken into consideration when switching from an oral product to an injection or between different types of injections, because side effects related to the original drug can emerge in this period.

Second-generation long-acting antipsychotic injections Risperidone was the first second-generation LAI to be licensed in the UK. The risperidone LAI antipsychotic works in a different...
way to the first-generation depot injections. Tiny polymer beads impregnated with the active compound are mixed with a diluent. After injection the diluent is quickly dissipated and the polymer beads break down over a period of a few weeks, slowly releasing the drug as they do so (Ramstack et al 2003). The drug will not reach a therapeutic level for a few weeks after injection, therefore it is essential that the patient receive alternative antipsychotic medication during the initial period of treatment following the first injection.

Test doses are not required as long as the service user has previously demonstrated tolerance to oral risperidone. Time to elimination from the body can be quicker and fall off more rapidly after the last injection, than in comparison with the oil-based depot injections. The importance of accepting the injection at regular intervals to prevent relapse must be considered when planning treatment. It is licensed for administration into the gluteus muscle. Other second- and third-generation LAIs are in development.

**Off-label and unlicensed medications** Most medicines that healthcare professionals use are licensed for a specific use and user group. This is a strict process, aimed at improving safety and ensuring that medicines in use are proven in how they work. However, some medicines are not licensed for certain user groups and, therefore, their use is known as ‘off-label’. An example of off-label use is often seen in medicines for children or people with a learning disability, because it is not ethical to undertake clinical trials on these groups. However, where these medicines are known to be effective, have a good safety record, and it is considered best practice to use them, practitioners will commonly prescribe and administer these medicines in the best interests of the patients to treat their condition.

Anyone who is to have a medicine that is off-label or unlicensed, for example, medicine that has not been granted a product licence for use in the UK, should be informed that the medicine is of a specific class, and made aware of the risks and benefits of such medicines so that they can make an informed decision about whether they wish to receive that particular medicine (Nursing and Midwifery Council (NMC) 2008a). Good practice points are listed in Box 4.

Details of an individual drug’s specific licensed indications are contained in its summary of product characteristics (SPC). Please refer to the British National Formulary, published twice a year and available online at www.bnf.org. SPCs and patient information leaflets are also available online via the electronic Medicines Compendium.
Healy (2005), Bazire (2007) and Taylor et al (2007) each provide accessible texts on pharmacology and more detailed prescribing information.

**Injection technique** Administering intramuscular injections should not be an isolated behaviour, but rather an important part of a process of medication management requiring thought and professional judgement (NMC 2008a). Knowledge and skills in anatomy, physiology, patient assessment, patient preparation and nursing intervention are all essential to fulfilling the role (Shepherd 2002).

Nurses need to be fully aware of the consequences and, by default of their registration, be accountable for their clinical interventions. Practice must be evidence based and demonstrate cogent understanding of the intervention and its context. Local protocols and procedures should be followed. Core principles of safe practice and an exemplar standard operating procedure for prescribing, preparing and administering injectable medicines are available from the National Patient Safety Agency (2007). In addition the good practice points in Box 5 should be noted.

**Monitoring** All clinicians who prescribe or administer medicines are accountable for the care that they give, and are responsible for undertaking a comprehensive assessment of the patient under their care. It is also their responsibility to ensure there is a valid prescription for the medicine they are administering. As part of their assessment a clinician looking after any patient will need to be aware of other current medications to ensure that medications are not contraindicated (NMC 2008a). All antipsychotic medication can give rise to unwanted effects. The purpose of this guide is not to list these verbatim, but nurses involved in the care of service users receiving depot or LAI antipsychotic treatment need to be aware of what unwanted symptoms might emerge. (See the pharmacology section for suggested resources.)

**Subjective experience of medication** Data on side effects and efficacy of medicines come from large clinical trial data sets and it should always be remembered that the experience of taking medication is subjective. Although some effects and side effects can be predicted from the pharmacology and can be measured systematically, the experience of the person taking

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**BOX 4**

**Good practice points**

- Be clear about the licensed indication for the injection, including any contraindications, interactions, the maximum dose, frequency and muscle for administration.
- Check allergy status of patients and staff, remembering that nut oil diluents are used in depot antipsychotic injections (not risperidone LAI).
- Use a test dose (not necessary with risperidone LAI where tolerance to oral risperidone is already demonstrated).
- Use the correct type of needle to make sure the active ingredient can travel down the needle bore. With risperidone LAI, always use the needle supplied in the pack.
- Consider absorption and elimination effects when starting, switching or stopping products.
The choice of injection site should be determined in conjunction with the service user, however reference to the individual product's SPC should be made to determine which sites are licensed because any deviation from these means the drug is being used off-label.

Injection sites should be rotated at each visit and the previous site examined.

Before administration, hands should be washed thoroughly and protective gloves worn. A non-touch technique should be used to prepare the injection according to the manufacturers' information.

The area in which medication is to be prepared should be as clean and uncluttered as possible and distractions and interruptions should be avoided.

Filter needles should not be used for drawing up depots, and only the needle supplied with the dose pack should be used for risperidone LAI.

Needles should be long enough to reach muscle and leave 5mm of the needle length clear of the skin. If the chosen needle is not long enough to reach muscle, the injection may be given into adipose tissue and this may affect the rate of absorption and potentially reduce the efficacy of the drug. The choice of needle for administration is, therefore, important. Nisbet (2006) suggests that the traditionally used green 21 gauge 35mm needle may not be long enough to reach muscle at the dorsogluteal site in many patients. Females are likely to have a deeper fat layer at this dorsogluteal site. Individual clinical judgement should be used depending on the size of the patient. A variety of lengths of green 21 gauge needles are available.

The site may be cleaned thoroughly for 30 seconds with a 70 per cent isopropyl alcohol swab and allowed to dry for at least 30 seconds before administering the injection (Lister and Sarpal 2004).

The use of the Z-track method is recommended as it reduces discomfort and prevents seepage back through the needle track (Rodger and King 2000). See Box 6, page 12.

Side effects

Regular systematic monitoring of side effects is essential using a validated tool, such as the Side Effect Scale/Checklist for the medicine and the observations of carers are equally important and should form a central part of any assessment or review. Lifestyle factors and personal preference should also be considered when making shared decisions about which drug is best to prescribe. Thus a patient with existing risk factors for cardiovascular disease should consider injections with a low propensity to cause weight gain. A patient in employment may wish to consider an injection that is less likely to cause sedation.

**Box 5**

**Good practice points**

- The choice of injection site should be determined in conjunction with the service user, however reference to the individual product’s SPC should be made to determine which sites are licensed because any deviation from these means the drug is being used off-label.
- Injection sites should be rotated at each visit and the previous site examined.
- Before administration, hands should be washed thoroughly and protective gloves worn. A non-touch technique should be used to prepare the injection according to the manufacturers’ information.
- The area in which medication is to be prepared should be as clean and uncluttered as possible and distractions and interruptions should be avoided.
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Antipsychotic Medication (SESCAM) (Bennett et al 1995) or the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) (Day et al 1995). Monitoring of physical health parameters is discussed in the next section.

Good practice dictates that monitoring should be carried out on a three-monthly basis and at least at every medication review. Both SESCAM and LUNSERS are broad scales and provide an indication of the presence of side effects. More focused outcome measures may be used to assess specific adverse events, for example the Abnormal Involuntary Movement Scale (for tardive dyskinesia) (National Institute of Mental Health (NIMH) 1976), Barnes Akathisia Scale (Barnes 1989). Cunningham-Owens (1999) describes in detail the assessment of extra pyramidal status.

In a recent study, ability to manage side effects was rated higher than the experience of side effects by patients – although the highest rated item was efficacy (Kikkert et al 2006).

Assessment of positive effects is, therefore, as important as assessment of side effects. Data from assessments should be used to inform a collaborative dialogue with patients about their experiences. Importantly, information should be exchanged about current coping strategies and how these may be enhanced. Using a problem-

**BOX 6**

**The Z-track technique**

- Immediately before injection, apply a shearing force with the non-dominant hand to the skin, approximately 25mm from the chosen injection site, thus sliding the dermal layer over the muscle.
- Holding the needle at 90° to the skin, quickly insert the needle (leaving 5mm on the outside). Pull back on the plunger; if no blood is aspirated continue. If blood is aspirated, discard the syringe and needle and start again using an alternative site.
- Slowly inject the contents of the syringe at a rate of 1ml per 10 seconds.
- Withdraw the needle quickly and immediately release the pressure on the skin. The natural elasticity of the skin returns the dermal layer to its former position, thus sealing the needle track.
solving approach to help patients identify and enhance their ways of coping with medication problems is important because these skills can often be generalised to other areas of their lives.

**Physical health**
Severe mental illness is associated with a higher incidence of physical illness and chronic disease (Brown 1997).

The most common physical conditions are:

**Cardiovascular disease** People with schizophrenia are twice as likely to have some form of cardiovascular disease in comparison with people who do not have schizophrenia (Brown 1997).

**Diabetes** The risk of diabetes in a person with schizophrenia is 14.9 per cent, compared with the 1.2 per cent to 6.3 per cent risk observed in the general population (Dixon *et al* 2000).

**Obesity** Evidence suggests excess weight gain can be two to three times more prevalent in people with schizophrenia than in the general population (Allison and Casey 2001). This may be due to high levels of smoking, unhealthy diets and lack of exercise – common lifestyle choices of people with schizophrenia (McCreadie 2003). However, antipsychotic medication can also exacerbate weight gain (Allison and Casey 2001). This antipsychotic treatment-induced weight gain increases both the risk for hyperglycaemia and type 2 diabetes, as well as the risk for hypertension and cardiovascular disease (Fontaine *et al* 2001).

These increased risks of physical disease may be more prevalent because of the difficulty accessing or receiving appropriate health care from primary and secondary services. Buntwal *et al* (1999) noted that 30 per cent of people with mental health problems using one mental health unit had been struck off a GP's list at some point. Despite evidence to suggest that people with schizophrenia have relatively high levels of contact with their GPs (Jablensky *et al* 2000), there appear to be inconsistencies in the way their problems are identified or managed. For example, studies have shown that patients with schizophrenia and heart disease have fewer blood pressure or recent cholesterol tests (Hippisley-Cox and Pringle 2005).

The English government has produced guidelines (NICE 2002, 2006) recommending that physical health checks for people with severe mental illness should normally be provided annually in primary care. To promote equality of access and quality of services, there needs to be systematic disease prevention and health promotion programmes in place to challenge
discrimination. This can be achieved by all organisations working collaboratively to provide services, which are fair, personal and responsive to patients’ needs and wishes (DH 2006b).

The General Medical Services contract stipulates that these regular, physical health checks are part of the mental health review alongside regular review of medication (British Medical Association 2006). However, if the service user is not in contact with primary care then secondary services should monitor his or her physical health.

Effective communication between healthcare professionals in primary and secondary care will help the service user benefit from physical assessment.

The Sainsbury Centre for Mental Health (2003) advocates that a physical health review for a person receiving treatment with an antipsychotic injection should include:

- Advice about diet, exercise, smoking, and substance and alcohol abuse.
- Protection against influenza by offering annual immunisation in view of increased occurrence of cardiac and respiratory disorders, and diabetes.
- Regular preventative care, for example cervical cytology.
- Routine monitoring of weight and blood pressure.
- Blood tests to measure glucose, cholesterol, and a full blood count.
- An electrocardiogram.

The healthcare professional may also consider blood tests to monitor liver function, thyroid function, kidney function and creatine phosphokinas (Taylor et al 2007). More recently, measuring the waist-to-hip ratio has been suggested as a method of measuring risk of cardiovascular disease (Yusuf et al 2005). A new tool has been developed to help nurses assess 28 physical health parameters and know what to do next if results are out of range (in print).

Follow up

Any healthcare professional with the responsibility of administering depot injections also has a responsibility to ensure there is a robust system that identifies and follows up service users who are not able to receive their injection on the due date.

Because of the pharmacokinetic profile of risperidone LAI, it is essential to follow up those service users who have missed a dose. As there is at least a three-week lag between the administration of the drug to effective dose level, the emergence of symptoms following a missed dose is not likely to be evident for at least three weeks. However, as the drug is eliminated more
quickly from the system than the older drugs, it is important to follow up the service user – ideally within a day of his or her missed dose.

With the slower time to elimination of the first generation depot antipsychotics, there is a greater window of opportunity for following up of those service users who have missed a dose. Assertive follow up is important, ideally within a few days of the missed dose.

**Maintaining knowledge and skills**

It is essential that all practitioners are aware of their responsibilities within the regulations and conduct governing their profession (NMC 2008b). With the development of *Agenda for Change* and the *Knowledge and Skills Framework* (DH 2004a, 2004b) implemented in most countries of the UK, it is incumbent on the practitioner to maintain professional knowledge and development. While the employer has an obligation to support employees during the course of their work, it is the responsibility of practitioners to maintain their contemporary practice by formal and informal methods, using the expertise of colleagues, patients, carers and others involved in their day-to-day work.

**Conclusion**

Antipsychotic medication remains a mainstay of treatment for people experiencing serious mental ill health. It is the professional, legal and ethical responsibility of those administering the medication to be suitably skilled in contemporary evidence-based techniques and to be academically equipped to support the medication management of those under their care.

This guide is not intended to be either definitive or exhaustive; it has been created to promote thinking and to stimulate further discussion. Local protocols and governance arrangements should still be followed, as long as they reflect current evidence; if they do not then it is the registered nurse's responsibility to challenge them. Where required, this guide might inform the review of such local arrangements, thereby encouraging a person-centred approach to LAI and depot management.
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Footnote:
*Many of the policy references in this guide apply to England. Despite this, it is intended that the spirit of this guide should be equally relevant to readers in Scotland, Wales and Northern Ireland.*

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