Australian Government
Aged Care Quality and Safety Commission

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Psychotropic self-assessment tool

Frequently asked questions

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This information is provided in response to questions received by the Commission in relation to use of the psychotropic self-assessment tool in residential aged care services.

Terminology alert

Because the words 'psychotropic', 'antipsychotic', 'psychosis', 'psychotic' and 'psychological' are all quite similar, there has been considerable confusion around their meaning. It is important that those making decisions where these words are relevant understand the different meanings and recognise that they are not interchangeable.

- The assessment tool is for drugs broadly known as **psychotropics**. Psychotropic medications are 'any drug capable of affecting the mind, emotions and behaviour'. More information on psychotropic medications can be found in the Psychotropic medications in aged care fact sheet.
- The National Aged Care Mandatory Quality Indicator Program is for reporting the class of drug '**antipsychotic**' which is one type of **psychotropic**.
- The 'P' in BPSD is '**psychological**' and not 'psychotic'. 'BPSD' does not constitute a diagnosis of psychosis. For information on the Behavioural and Psychological Symptoms of Dementia see Dementia Support Australia.
- '**Psychosis**' or '**psychotic**' are medical terms with clear diagnostic criteria. It is a diagnosis that can only be made by a clinician on the basis of clear and well documented symptoms, and should have investigation and management strategies, often including expert advice.
- A number of types of psychotropic drugs are used as **chemical restraints**. The restraint relates to their use in an individual consumer and not to the drug itself. Some medications are more commonly used as restraint. Information and resources on restrictive practices are available here.

What is the psychotropic self-assessment tool?

The self-assessment tool has been developed to assist providers to understand which consumers in a service have been prescribed psychotropic medications, and what opportunities there may be to reduce or remove these medications for these consumers.

Is use or completion of the psychotropic self-assessment tool mandatory?

No. Completion of the tool is voluntary. It helps consolidate information for a provider in order to monitor and manage risks to consumers.

Information in the psychotropic assessment tool may be used by Commission staff as part of ongoing assessment and monitoring activities.

Does the psychotropic self-assessment tool have to remain in this form, or can it be customised for each service?

Providers can customise the self-assessment tool as they see fit to suit their services. Alternatively, providers are encouraged to develop customised ways of monitoring prescription and use of psychotropic medication for their consumers, including for use as chemical restraint, as part of organisational governance and managing risks to individual consumers.

How can the tool assist the service's clinical governance and/or Medication Advisory Committee?

Use of the tool enhances provider understanding of the extent of, and how, psychotropic medications are used at the service. This can highlight areas which a provider may wish to review, audit or increase oversight. Understanding of the service's use of psychotropic medications can point to gaps in processes or knowledge and trigger education on relevant issues. These may include restraint, consent, behaviour management, monitoring and review, polypharmacy, medication charting, storage and security, or PRN governance as examples.

Use of the tool can also alert the provider to individual consumers who may be at risk or need a behaviour support plan, more monitoring, reassessment, re-discussion of consent, or expert review.

Is the self-assessment tool only used to record psychotropic medications prescribed as chemical restraint?

No. Psychotropics as a group are high-risk medications often associated with potentially harmful and distressing side effects. These risks can be compounded when a consumer is prescribed more than one, as the drugs can interact and potentiate each other, contributing significantly to drug risks and harm. Providers should have oversight and safe management of high-risk medication use regardless of whether it is being used as a chemical restraint.

Is there an easy way to differentiate the reason for psychotropic use and identify that it is for chemical restraint?

There is no 'tick box' or 'one size fits all' approach. Medications must be considered in the context of their use in each person and as that person's situation or condition changes. If a person is agitated and appears anxious, some may have a true anxiety disorder, some may have depression, and others may have BPSD. Others will be bored, lonely, uncomfortable, in pain or in need of reassurance, family contact or meaningful pleasurable activities. It is not always easy to differentiate and often there is more than one contributor. Robust, well-documented attempts to understand the individual and their reaction to different situations must always be made.

Different practitioners may at times reasonably come to different conclusions. That is why it is always important to document the rationale for the conclusion reached or decision made. A medication can be used to treat a medical condition or mental illness, but can also be used as a chemical restraint if it has also been prescribed with the intention of managing behaviour e.g. limit a person's wandering, agitation or calling out.

Where a decision is made by the provider in relation to what does or does not constitute chemical restraint, the rationale must be clear. By way of example, if 'psychosis' is documented as the indication then the clear clinical basis and criteria on which the diagnosis has been made, and the need to manage that condition with medication, should also be documented. Agitation, for example, cannot be merely renamed 'psychosis' in an attempt to avoid classifying a medication use as chemical restraint.

Asking a GP to document 'not restraint' does not constitute the rationale for a provider deciding that medication use is not restraint. GPs may be unfamiliar with the legislation governing use of restrictive practices in aged care: 'Quality of Care Principles' that applies to providers.

For further resources to help with this decision, see our Minimising restrictive practices web page, including explanatory scenarios and decision-making tool.

How does a provider know if a medication, including psychotropic medication, is used as chemical restraint?

The rationale for use of chemical restraints must be clear and documented, and supported by the provider's processes and clinical governance framework. Use of chemical restraints for any consumer must be supported by a behaviour support plan, and include the legislative requirements for use of the medication as a last resort.

If, for example, a consumer has been diagnosed by a medical professional with psychosis, this should be documented, including any appropriate assessments. The subsequent need to manage that condition with appropriate medication should also be documented. Agitation, however, cannot merely be renamed 'psychosis' by a non-qualified staff member in an attempt to avoid classifying use of a medication as chemical restraint.

Who can give consent for prescription of psychotropic medications?

The person who is the subject of the prescription can give consent. If they lack capacity, then substitute decision-maker mechanisms exist under different State and Territory laws. The Australian Government is currently seeking to provide a legal basis for alternative consent arrangements where this mechanism is not yet available in a particular state/territory. For further information, see our Consent for medication fact sheet and Frequently asked questions about consent, Capacity Australia, Older Persons Advocacy Network — your choice.

Who should gain informed consent for medication?

Gaining informed consent for medication, including when used as chemical restraint, is the responsibility of the prescriber. This is detailed in many relevant sections of the Medical Board of Australia and Nursing and Midwifery Board documents: Good medical practice: a code of conduct for doctors in Australia and the Nursing and Midwifery Board standards for practice.

The provider must have a mechanism to satisfy themselves that informed consent has been obtained by the prescriber. This mechanism will vary depending on the service's systems, and arrangements made between the service and individual prescribers. Providers should not be obtaining informed consent themselves for medication as they will rarely have sufficient knowledge of the reasons a prescribing practitioner chose to offer a particular medication, how it will affect the individual person in the context of their medical condition, and potential side effects and interactions with other medications. For resources on consent for medication, see our Consent for medication fact sheet and Frequently asked questions about consent, and the Older Persons Advocacy Network — your choice resources.

Is consent only required for psychotropics prescribed for and used as chemical restraint?

No. Any significant medical treatment, including prescription of medication, requires informed consent. The more complex or risky the treatment is, the more information needs to be given to enable the person to decide whether they wish to consent to the treatment offered. Psychotropics have considerable risks associated with them whether they are used to treat a diagnosed condition and/or to manage behaviour. As a result, the consent process needs to be thorough and must be documented. It also needs to be reviewed in a timeframe which reflects an understanding of the way the medication is expected to work and the side effects that may occur in each case.

New medication needs early review for effectiveness, and detrimental effects and consent will need to be reviewed if the medication is not working as anticipated, if new risks emerge and/or if dose alterations are suggested.

See our Consent for medication fact sheet and Frequently asked questions about consent, and the Older Persons Advocacy Network — your choice resources for further information.

If someone asks for a psychotropic medication, does that mean they are consenting to it?

No. Someone can ask for a medication that they might not actually want, once they become aware of, and understand, all the options, effects, risks and side effects. Informed consent involves discussion of all the alternatives to, and pros and cons of, the requested medication in the individual person's context. People may also ask for medications they are dependent on without understanding the implications of their continued use. A prescriber is under no obligation to prescribe a medication just because it is requested. The prescriber has to be satisfied that the medication use is justified, of sufficient potential benefit to the person to outweigh the risk of potential harm, and for a clearly documented reason.

Does every episode of PRN (pro re nata) administration require separate consent?

Not usually, but circumstances in which a person giving consent wishes to be informed should be discussed if not clear. If the consumer themselves is giving consent, they should be involved in the discussion on each occasion of PRN use. Where a substitute decision-maker consents to PRN psychotropic medication, it should include a clear stipulation for the circumstances in which it can be used. There would normally be consent such as e.g. 'risperidone 0.5mg PRN for severe agitation after other measures in the behaviour support plan have been implemented'. This means that consent has been given if these are the circumstances. If the consent includes a clause such as 'notify consenter on each PRN use occasion' then this should be done and noted. The provider should ask the consenter what their preference is in this circumstance, and this decision should be noted.

Should PRN psychotropic medications be included in the self-assessment tool?

Yes. Psychotropics prescribed as PRN are a high-risk sub-group where there is staff discretion about timing and frequency of use. If they are prescribed, and then administered, they therefore pose a risk to the consumer. Providers need to have oversight of use of PRN psychotropic medications for consumers in their service. If PRN psychotropics that are prescribed are not being administered, then review of their ongoing need should be requested. Prescription of these medications should be ceased if no longer used or required.

Do PRN psychotropics have to be included in monitoring?

Yes. As noted above, PRN psychotropics are a high-risk sub-group where there is staff discretion about timing and frequency of their use. If they are prescribed, then they can be administered, and therefore pose a risk to the consumer. Providers need to have oversight of the use of PRN medications for consumers in their service.

Providers need to monitor PRN psychotropic use for side effects, efficacy and ongoing need. Providers need to ensure that they are only administered as a last resort on each occasion where they constitute chemical restraint, and only in the exact circumstances indicated by the prescriber and/or stipulated by the person giving consent.

These circumstances for use need to be clear on the medication chart and outlined in a behaviour support plan.

Non-drug strategies tried before PRN psychotropics are administered for behaviour need to be fully outlined in the consumer's behaviour support plan. Non-drug strategies and non-psychotropic medication, such as simple analgesics for pain, should be explored before PRN psychotropic medication is used.

PRN psychotropic use that is frequent or escalating should trigger a review to determine reasons behind these changes. The alternative strategies, circumstances for appropriate use of PRN medication, staff factors, reasons for any deterioration in health or behaviour changes should be reviewed and evaluated.

Monitoring for effectiveness and side effects should still occur with any PRN medication use.

It is worth noting that the PRN use of antipsychotics usually constitutes chemical restraint as administration is triggered by a behaviour of some sort. This is the case even if a person is also on regular antipsychotics to treat a condition such as schizophrenia.

What medications are considered psychotropics?

The Commission has developed a list of psychotropic medications, which is available here.

Why are psychotropics a high-risk group of medications?

They work on the brain and nervous system, and can affect alertness, balance, cognition/thinking, memory, judgement, appetite, mood, motivation, participation, independence and quality of life. Some psychotropics cause respiratory depression and some are associated with increased risk of cardiovascular complications and death.

Psychotropics have limited effectiveness in many conditions and in many people.

Sedation is a common effect or side effect of psychotropic medication. Sedation causes risk of pressure injuries, falls, nutritional decline, pneumonia, physical deconditioning and reduced interaction and communication. These all affect quality of life.

Used in combination, the risks associated with psychotropics are higher.

Psychotropics contribute to polypharmacy, drug burden index, risk of serotonin syndrome, extrapyramidal effects and over-sedation. Some, including benzodiazepines and opioids, are associated with tolerance and dependence. Pharmacists can sometimes help measure the drug burden index for individual consumers.

Are metoclopramide (Maxolon) and prochlorperazine (Stemetil) psychotropics?

Strictly speaking, yes. However, their effects on the brain are limited so some providers choose not to include them in the tool whereas others wish to. They are chemically similar to antipsychotics that block dopamine in the brain and it should be noted that these drugs can have psychotropic side effects in some vulnerable people. If a consumer becomes drowsy after taking these anti-nausea medications it can worsen the sedating effects of other psychotropic agents. There is known overuse of Stemetil, and Maxolon in aged care causing extrapyramidal side effect risks, so they should be reviewed regularly, whether or not the service decides to include them in this tool.

Is Melatonin a psychotropic?

Strictly speaking, yes. Melatonin is an over-the-counter medication often classified as a weak psychotropic medication as its primary purpose is to affect sleep. Notably, melatonin has fewer side effects and less daytime drowsiness than stronger hypnotics such as benzodiazepines and 'z-drugs'. In vulnerable people melatonin can worsen the sedative effects of other psychotropic medication, so should be monitored.

Is medicinal Marijuana (or cannabis) a psychotropic?

Yes. Medicinal cannabis, including forms sold over the counter, is sometimes used in an attempt to reduce anxiety and pain in certain conditions such as neurodegenerative illness, although evidence for its effect is limited. Like many other psychotropic agents, medicinal cannabis can enhance the sedative and other side effects of other psychotropic medication, so needs to be monitored.

In Australia the preparations are variable in the active ingredients they contain, and their likely benefits and potential risks in each individual need to be carefully considered.

Individual states and territories have specific guidance on authorisation for medicinal marijuana/medicinal cannabis, which should be considered prior to prescribing. Providers should be aware of these requirements.

Medical marijuana/cannabis should be recorded in the self-assessment tool.

More information is available from the following sources:

nps.org.au/professionals/medicinal-cannabis-what-you-need-to-know

nps.org.au/assets/Medicinal-cannabis-FAQs-new.pdf

australiancannabinoidresearch.com.au/resources

tga.gov.au/medicinal-cannabis

The Aged Care Quality and Safety Commission acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

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