Institution Name: Al Masarra Hospital

Document Title: Clinical Guideline for the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD/ADD)

Approval Process

	Name	Title	Institution	Date	Signature
Written by	Dr. Walid Hassan	Specialist	Al Masarra Hospital	19.12.2022	walid Hassan
	Dr. Amira Zaky	Specialist	Al Masarra Hospital	19.12-22	Amira Zaky
	Badriya ALGhammari	SSN	Al Masarra Hospital	20.12.22	
Reviewed by	Dr. Yahya ALKalbani	Senior Specialist	Al Masarra Hospital	19.12.22	
Validated by	Kunooz Al Balushi	Document Manager	Al Masarra Hospital	Dec 2022	
Approved by	Dr.Bader ALHabsi	Executive Director	Al Masarra Hospital	Jan 2023	

AL-MASARRA HOSPITAL HOSPITAL MANAGER SULTANATE OF OMAN- MINISTRY OF HEALTH

Content Table:

Acronyms

AMRH	Al Masarra Hospital
WHO	World Health Organization
ADHD	attention deficit hyperactivity disorder
e.g.	Example
ICD-10	International statistical classification of diseases
DSM-5	Diagnostic and statistical manual of mental disorders
FDA	Food and drug administration
BNF	British national formulary

Clinical Guideline for the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD/ADD)

1. Introduction

This guideline addresses the management of Attention Deficit Hyperactivity Disorder in child in Al-Masarra Hospital. It provides clear and comprehensive evidence based recommendations incorporating the latest international guidelines and practices in the treatment of ADHD/ADD.

Attention Deficit Hyperactivity Disorder (ADHD) is typically a chronic, often lifelong, condition. The impact and presentation of ADHD can change over time and often requires lifelong monitoring and treatment. Health care providers concern that follows the patients / patient's next of kin or legally authorized representative should be knowledgeable about how ADHD presents and causes functional impairment across the lifespan.

2. Scope

This document is applicable to all healthcare providers in Al Masarra Hospital (AMRH) who have direct involvement in ADHD patients care

3. Purpose

3.1 To provide clear information among healthcare providers about their professional responsibilities in providing the ADHD patients, or next of kin / legally authorized representative with updated information regarding ADHD disorder and management.

4. Definitions

4.1 Attention-deficit/hyperactivity disorder (ADHD). ADHD is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

4.2 Inattention. Inattention means a person wanders off task, lacks persistence, has difficulty sustaining focus, and is disorganized; and these problems are not due to defiance or lack of comprehension.

4.3 Hyperactivity. Hyperactivity means a person seems to move about constantly, including in situations in which it is not appropriate; or excessively fidgets, taps, or talks.

4.4 Impulsivity. Impulsivity means a person makes hasty actions that occur in the moment without first thinking about them and that may have high potential for harm; or a desire for immediate rewards or inability to delay gratification.

5. Policy

5.1 Healthcare workers concern must be aware and adherence of clinical guideline for the diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD).

6. Guidelines

6.1 Diagnostic criteria

6.1.1 Symptoms of hyperkinetic disorder in ICD-10

6.1.1.1 Hyperactivity

6.1.1.1.1. Often fidgets with hands or squirms in seat

6.1.1.1.2. Difficulty remaining seated when required

6.1.1.1.3. Runs about or climbs on things excessively in situations when it is inappropriate

6.1.1.1.4. Exhibits a persistent pattern of motor activity (always on the go)

6.1.1.1.5. Often noisy in playing or difficulty engaging quietly in leisure activities

6.1.1.2 Inattention

6.1.1.2.1 Fails to sustain attention in tasks or play activities

6.1.1.2.2 Often fails to follow through on instructions from others

6.1.1.2.3 Often avoids tasks that require sustained mental effort

6.1.1.2.4 Often easily distracted

6.1.1.2.5 Often loses things that are necessary for tasks or activities

6.1.1.2.6 Appears not to listen to what is being said to him/her

6.1.1.2.7 Fails to pay attention to details, or makes careless mistakes

6.1.1.2.8 Often forgetful in daily activities

6.1.1.2.9 Often has difficulty organizing tasks and activities

6.1.1.3 Impulsivity

6.1.1.3.1 Difficulty waiting turn in games or group situations

6.1.1.3.2 Often blurts out answers before questions have been completed

6.1.1.3.3 Often interrupts or intrudes on others

6.1.1.3.4 Often talks excessively

6.1.1.4 Other

6.1.1.4.1 Onset before the age of 7 years

6.1.1.4.2 Like all neurodevelopmental disorders, boys are more commonly affected than girls. The male: female sex ratio is higher in clinics (7–8:1) than in the community (3–4:1), suggesting that ADHD in females is under-recognized.

6.1.2 DSM-5 Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

6.1.2.1 A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by:

6.1.2.1.1 **Inattention**: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

6.1.2.1.1.1 Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

6.1.2.1.1.2 Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

6.1.2.1.1.3 Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

6.1.2.1.1.4 Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily side-tracked).

6.1.2.1.1.5 Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belonging in order; messy, disorganized work; has poor time management; fails to meet deadlines).

6.1.2.1.1.6 Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

6.1.2.1.1.7 Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, and mobile telephones).

6.1.2.1.1.8 Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

6.1.2.1.1.9 Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

6.1.2.1.2 **Hyperactivity and impulsivity**: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

6.1.2.1.2.1 Often fidgets with or taps hands or feet or squirms in seat.

6.1.2.1.2.2 Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place)

6.1.2.1.2.3 Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)

6.1.2.1.2.4 Often unable to play or engage in leisure activities quietly.

6.1.2.1.2.5 Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

6.1.2.1.2.6 Often talks excessively.

6.1.2.1.2.7 Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

6.1.2.1.2.8 Often has difficulty waiting his or her turn (e.g., while waiting in line).

6.1.2.1.2.9 Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's

things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

6.1.2.2 Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

6.1.2.3 Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

6.1.2.4 There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

6.1.2.5 The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

6.1.2.6 Specify whether:

6.1.2.6.1 31 4.01 (F90.2) Combined presentation: If both Criterion A 1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.*(Refer to appendix 1 : Common Comorbidities : Psychiatric comorbidity)*

6.1.2.6.2 314.00 (F90.0) Predominantly inattentive presentation: If Criterion A 1 (inattention) is met but Criterion A2 (hyperactivity/impulsivity) is not met for the past 6 months. .*(Refer to appendix 1 : Common Comorbidities : Psychiatric comorbidity)*

6.1.2.6.3 314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A 1 (inattention) is not met for the past 6 months. .*(Refer to appendix 1 : Common Comorbidities : Psychiatric comorbidity)*

6.1.2.6.4 Specify if: In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months,

and the symptoms still result in impairment in social, academic, or occupational functioning.

6.1.2.6.5 Specify current severity: Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

6.1.2.6.6 Moderate: Symptoms or functional impairment between "mild" and "severe" are present.

6.1.2.6.7 Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

6.2 Red Flags for ADHD

6.2.1 Organizational skill problems (time management difficulties, missed appointments, frequent late and unfinished projects).

6.2.2 Erratic work/academic performance.

6.2.3 Anger control problems.

6.2.4 Family/marital problems.

6.2.5 Difficulty in maintaining organized household routines, sleeping patterns and other self-regulating activities.

6.2.6 Difficulty managing finances.

6.2.7 Addictions such as substance use, compulsive shopping, sexual addiction, overeating, compulsive exercise, video gaming or gambling.

6.2.8 Frequent accidents either through recklessness or inattention.

6.2.9 Problems with driving (speeding tickets, serious accidents, license revoked).

6.2.10 Having a direct relative who has ADHD.

6.2.11 Having to reduce their course load, or having difficulty completing assignments in school.

6.2.12 Low self-esteem or chronic under-achievement

6.3 DIFFERENTIAL DIAGNOSIS AND COMORBID DISORDERS

6.3.1 50-90% of children with ADHD have at least one comorbid condition.

6.3.2 Approximately half of all children with ADHD have at least two comorbidities

6.3.3 85% of adults with ADHD meet criteria for a comorbid condition.

6.3.4 There are multiple potential explanations for the existence of comorbidities and/or overlapping symptoms between ADHD and other disorders. The main explanations are:

6.3.4.1 One disorder is a precursor to another.

6.3.4.2 One disorder is a risk factor for developmental of the other.

6.3.4.3 The disorders share the same related risk factors

6.3.4.4 There is a common underlying symptomatic basis for one or more of the behaviours in common.

6.3.4.5 As ADHD does not have a symptom that is pathognomonic for the condition, there can be numerous overlaps with other disorders.

6.3.4.6 For common comorbidities (*Refer to appendix 1 : Common Comorbidities*)

6.4 Diagnosis of ADHD

6.4.1 Clinical interview for the parents or caregivers and observe their interaction

6.4.1.1. Discuss symptoms and signs suggesting ADHD

6.4.1.2.Review the developmental history

6.4.1.3.Consider any psychiatric comorbidity

6.4.2 Medical interview:

6.4.2.1 Screen for medical problems with presentations similar to ADHD

6.4.2.2 Contraindications for the ADHD medications

6.4.3. ADHD Questionnaires:

6.4.3.1 Can be added to fulfill the diagnosis

6.4.3.2 Shall be used for parents and teachers

6.4.3.3 Check the appendix for Vanderbilt Questionnaire

6.4.4 Tests and labs

6.4.4.1 ADHD/ADD is still a clinical diagnosis. There is no specific single psychological test or brain scan that rules in the diagnosis of ADHD/ADD

6.4.4.2 Consider sleep study, EEG, ferritin and thyroid levels when indicated from history

6.4.4.3 Psychological testing can be useful to rule in diagnosis (in subtle cases particularly in ADHD inattentive type) and rule out other issues such as learning disability or borderline intellectual functioning

6.5 Treatment

6.5.1 Treatment choice according to age

6.5.1.1 **Children ages 4-6 years**

6.5.1.1.1 The first line of treatment should include parent training in behaviour management and/or behavioural classroom interventions (if available). *(Refer to appendex 2 : Parent Training in Behaviour Management for ADHD* and *Behavioural classroom interventions)*

6.5.1.1.2 Methylphenidate may be used if behavioural interventions do not provide significant improvement and the child continues to have serious problems.

6.1.1.2 Children and adolescents 6-18 years

6.1.1.2.1 Recommended treatment for children and adolescents includes FDA-approved medications along with Parent training in behaviour management and/or Behavioural classroom interventions.

6.1.1.2.2 Treatments often work best when used together.

6.1.1.2.3 For all children attending school, the school is a necessary part of any treatment plan. These plans can include educational interventions; and individual school supports, such as school environment and behavioural supports.

6.1.1.2.4 For more details of Non pharmacological interventions. *(Refer to Appendix (2): Non-pharmacological interventions*.)

6.6 Medications

6.6.1 All medication for ADHD should only be initiated by a healthcare professional with training and expertise in diagnosing and managing ADHD.

6.6.2 Healthcare professionals initiating medication for ADHD should:

6.6.2.1 be familiar with the pharmacokinetic profiles of all the short- and long-acting preparations available for ADHD

6.6.2.2 ensure that treatment is tailored effectively to the individual needs of the child, young person or adult

6.6.2.3 Take account of variations in bioavailability or pharmacokinetic profiles of different preparations to avoid reduced effect or excessive adverse effects.

6.6.3 Baseline assessment

6.6.3.1 Before starting medication for ADHD, people with ADHD should have **a full assessment**, which should include:

6.6.3.1.1 A review to confirm they continue to meet the criteria for ADHD and need treatment

6.6.3.2 **A review of mental health and social circumstances**, including:

6.6.3.2.1 Presence of coexisting mental health and neurodevelopmental conditions

6.6.3.2.2 current educational or employment circumstances

6.6.3.2.3 risk assessment for substance misuse and drug diversion

6.6.3.3 **A review of physical health**, including:

6.6.3.3.1 A medical history, taking into account conditions that may be contraindications for specific medicines

6.6.3.3.2 Current medication – height and weight (measured and recorded against the normal range for age, height and sex)

6.6.3.3.3 Baseline pulse and blood pressure (measured with an appropriately sized cuff and compared with the normal range for age)

6.6.3.3.4 A cardiovascular assessment. An electrocardiogram (ECG) is not needed before starting stimulants, atomoxetine or guanfacine, unless the person has any of the features in recommendation a co-existing condition that is being treated with a medicine that may pose an increased cardiac risk.

6.6.3.4 **Refer for a cardiology opinion** before starting medication for ADHD if any of the following apply:

6.6.3.4.1 history of congenital heart disease or previous cardiac surgery

6.6.3.4.2 history of sudden death in a first-degree relative under 40 years suggesting a cardiac disease

6.6.3.4.3 shortness of breath on exertion compared with peers

6.6.3.4.4 fainting on exertion or in response to fright or noise

6.6.3.4.5 palpitations that are rapid, regular and start and stop suddenly (fleeting occasional bumps are usually ectopic and do not need investigation)

6.6.3.4.6 chest pain suggesting cardiac origin

6.6.3.4.7 signs of heart failure

6.6.3.4.8 a murmur heard on cardiac examination

6.6.3.5 **Refer to a pediatric hypertension specialist** before starting medication for ADHD if blood pressure is consistently above the 95th centile for age and height for children and young people.

6.6.4 **Medication choice – children aged 5 years and over and young people**

6.6.4.1 Offer methylphenidate (either short or long acting) as the first line pharmacological treatment for children aged 5 years and over and young people with ADHD

6.6.4.2 Offer atomoxetine or guanfacine to children aged 5 years and over and young people if:

6.6.4.2.1 they cannot tolerate methylphenidate

6.6.4.2.2 Their symptoms have not responded to separate 6-week trials of methylphenidate, having considered alternative preparations and adequate doses.

6.6.4.3 Do not offer any of the following medication for ADHD without advice from a tertiary ADHD service:

6.6.4.3.1 clonidine for children with ADHD and sleep disturbance, rages or tics (off-label use)

6.6.4.3.2 Atypical antipsychotics in addition to stimulants for people with ADHD and coexisting pervasive aggression, rages or irritability medication not included in recommendations.

6.6.5 **Medication choice – people with coexisting conditions**

6.6.5.1 Offer the same medication choices to people with ADHD and anxiety disorder, tic disorder or autism spectrum disorder as other people with ADHD.

6.6.5.2 For children aged 5 years and over, young people and adults with ADHD experiencing an acute psychotic or manic episode:

6.6.5.2.1 stop any medication for ADHD

6.6.5.2.2 Consider restarting or starting new ADHD medication after the episode has resolved, taking into account the individual circumstances, risks and benefits of the ADHD medication.

6.6.6 Considerations when prescribing ADHD medication

6.6.6.1 When prescribing stimulants for ADHD, think about modified-release once daily preparations for the following reasons: convenience improving adherence reducing stigma (because there is no need to take medication at school or in the workplace) reducing problems of storing and administering controlled drugs at school the risk of stimulant misuse and diversion with immediate-release preparations their pharmacokinetic profiles.

6.6.6.2 Immediate-release preparations may be suitable if more flexible dosing regimens are needed, or during initial titration to determine correct dosing levels.

6.6.6.3 Be cautious about prescribing stimulants for ADHD if there is a risk of diversion for cognitive enhancement or appetite suppression.

6.6.7 Dosing and treatment algorithm *(refer to Appendix (3): Medication dosing)*

6.6.8 Dose titration

6.6.8.1 During the titration phase, ADHD symptoms, impairment and adverse effects should be recorded at baseline and at each dose change on standard scales by parents and teachers, and progress reviewed regularly (for example, by weekly telephone contact) with a specialist.

6.6.8.2 Titrate the dose against symptoms and adverse effects in line with the BNF or BNF for Children until dose optimisation is achieved, that is, reduced symptoms, positive behaviour change, improvements in education, employment and relationships, with tolerable adverse effects.

6.6.8.3 Ensure that dose titration is slower and monitoring more frequent if any of the following are present in people with ADHD:

6.6.8.4 Neurodevelopmental disorders (for example, autism spectrum disorder, tic disorders, learning disability ,intellectual disability)

6.6.8.5 Mental health conditions (for example, anxiety disorders including obsessive–compulsive disorder, schizophrenia or bipolar disorder, depression, personality disorder, eating disorder, post-traumatic stress disorder, substance misuse)

6.6.8.6 Physical health conditions (for example, cardiac disease, epilepsy or acquired brain injury).

6.6.9 **Maintenance and monitoring**

6.6.9.1 Monitor effectiveness of medication for ADHD and adverse effects, and document in the person's notes.

6.6.9.2 Encourage people taking medication for ADHD to monitor and record their adverse effects, for example, by using an adverse effect checklist.

6.6.9.3 Consider using standard symptom and adverse effect rating scales for clinical assessment and throughout the course of treatment for people with ADHD.

6.6.9.4 Ensure that children, young people and adults receiving treatment for ADHD have review and follow-up according to the severity of their condition, regardless of whether or not they are taking medication.

6.6.9.5 For special monitoring (*refer to Appendix (4) Monitoring of medications)*

6.6.10 **Adherence to treatment**

6.6.10.1 Be aware that the symptoms of ADHD may lead to people having difficulty adhering to treatment plans (for example, remembering to order and collect medication).

6.6.10.2 Ensure that people are fully informed of the balance of risks and benefits of any treatment for ADHD and check that problems with adherence are not due to misconceptions (for example, tell people that medication does not change personality).

6.6.10.3 Encourage the person with ADHD to use the following strategies to support adherence to treatment:

6.6.10.3.1 being responsible for their own health, including taking their medication as needed

6.6.10.3.2 Following clear instructions about how to take the medication in picture or written format, which may include information on dose, duration, adverse effects, dosage schedule (the instructions should stay with the medication, for example, a sticker on the side of the packet)

6.6.10.3.3 Using visual reminders to take medication regularly (for example, apps, alarms, clocks, pill dispensers, or notes on calendars or fridges)

6.6.10.3.4 Taking medication as part of their daily routine (for example, before meals or after brushing teeth) attending peer support groups (for both the person with ADHD and for the families and carers).

6.6.10.4 Encourage parents and carers to oversee ADHD medication for children and young people. Supporting adherence to non-pharmacological treatments

6.6.10.5 Support adherence to non-pharmacological treatments (for example, CBT) by discussing the following:

6.6.10.5.1 The balance of risks and benefits (for example, how the treatment can have a positive effect on ADHD symptoms).

6.6.10.5.2 the potential barriers to continuing treatment, including: not being sure if it is making any difference

6.6.10.5.3 the time and organizational skills needed to commit to the treatment

6.6.10.5.4 the time that might be needed outside of the sessions (for example, to complete homework)

6.6.10.5.5 strategies to deal with any identified barriers (for example, scheduling sessions to minimize inconvenience or seeking courses with child care provision)

6.6.10.5.6 a possible effect of treatment being increased self-awareness, and the challenging impact this may have on the person and the people around them

6.6.10.6 The importance of long-term adherence beyond the duration of any initial programme (for example, by attending follow-up/refresher support to sustain learned strategies).

6.6.11 **Review of medication and discontinuation**

6.6.11.1 A healthcare professional with training and expertise in managing ADHD should review ADHD medication at least once a year and discuss with the person with ADHD (and their families and carers as appropriate) whether medication should be continued.

6.6.11.2 The review should include a comprehensive assessment of the:

6.6.11.2.1 Preference of the child, young person or adult with ADHD (and their family or carers as appropriate)

6.6.11.2.2 Benefits, including how well the current treatment is working throughout the day

6.6.11.2.3 Adverse effects

6.6.11.2.4 Clinical need and whether medication have been optimized

6.6.11.2.5 Impact on education and employment

6.6.11.2.6 Effects of missed doses, planned dose reductions and periods of no treatment.

6.6.11.2.7 Effect of medication on existing or new mental health, physical health or Neurodevelopmental conditions.

6.6.11.2.8 Need for support and type of support (for example, psychological, educational, and social) if medication has been optimized but ADHD symptoms continue to cause a significant impairment.

6.6.11.3 Encourage people with ADHD to discuss any preferences to stop or change medication and to be involved in any decisions about stopping treatments.

6.6.11.4 Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If the decision is made to continue medication, the reasons for this should be documented.

7 Responsibility

7.1 Psychiatrists shall :

7.1.1 Adhere to safe management according to ADHD guideline.

7.1.2 Assessment of ADHD typically involves the comprehensive evaluation of information gathered from a number of sources, including parents/carers, family members, teachers, partners and colleagues, depending on the age of the patient

7.1.3 Ensure full physical assessment carried out including necessary investigation

7.1.4 Provisional diagnosis and information of care plan including observation and treatment

7.1.5 Referral to other multidisciplinary team for assessment

7.1.6 Finalize diagnosis with comprehensive risk assessment by the multidisciplinary team

7.1.7 Implement integrated team intervention and management

7.1.8 Monitor progress.

7.2 General Nursing Interventions for ADHD Patient

7.2.1 Nurses must be knowledgeable enough in taking care of patients with ADHD; environmental and behavioral settings should be taken into consideration

7.2.2 Approach the child at his/her current level of functioning. Do not use baby talk nor direct him/her as to child chronological age; encourage to express thoughts or emotions and respond to client therapeutically.

7.2.3 Use simple and direct instructions. Repeat the instructions more than once and at times, utilize visual aids or pictures in order to relate well; in educating the child, the lessons should only be brief in duration due to short attention span.

7.2.4 Implement scheduled routine every day. Make the child routine predictable and something like ritualistic so that it will only be easy to grasp for independent functioning.

7.2.5 Avoid stimulating or distracting settings. Ensure to involve the child in daily activities in a quiet and non-stimulating area to prevent becoming hyperactive and easily distracted.

7.2.6 Encourage physical activity. encourage to join a physical activity that he /she likes as this may also help him make friends with other children; allow to exert his energy productively but do not let him get over fatigued, physical activity helps in getting good sleep but over fatigue might as well uneasy and irritable.

7.2.7 Implemented appropriate memory retraining techniques, such as keeping calendar, writing list, memory cue games, mnemonic device using computers, and so forth

7.2.8 Encouraged ventilation of feelings of frustration helplessness, and so forth; refocused attention to areas of control and progress.

7.2.9 Provided for / emphasized importance of pacing learning activities and having appropriate rest.

7.2.10 Monitored client's behavior and assist in using stress management techniques

7.2.11 Maximizing the level of functioning

7.2.11.1 Assess the patient ability to carry out activities of daily living.

7.2.11.2 Avoid promoting dependence.

7.2.11.3 Reward positive behavior.

7.2.12 Promoting Social skills

7.2.12.1 Encourage the patient to engage in meaningful interpersonal relationships.

7.2.12.2 Provide support to assisting him to learn social skills.

7.2.13 Promoting Compliance and monitoring Drug therapy

7.2.13.1 Administer prescribed drugs to manage ADHD symptoms

7.2.13.2 Encourage the patient to comply with the medication regimen to prevent relapse.

7.2.13.3 Regularly assess the patient for adverse side effects.

7.3 **Psychologists:**

7.3.1.1 Psychological testing to rule in diagnosis (in subtle cases particularly in ADHD inattentive type) and rule out other issues such as learning disability or borderline intellectual functioning

7.3.1.2 Parent Training in Behaviour Management for ADHD :Psycho – education about the illness , psycho education about the triggers and how to deal with it ,how to deal with patient relapse and support the child in correct way

8 Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Dr. Walid Hassan Dr. Amira Zaky Badriya Al Ghammari	
02	**Update**		
Written by	**Reviewed by**	**Approved by**	
Dr. Walid Hassan Dr. Amira Zaky Badriya Al Ghammari	Dr. Yahya Al Kalbani	Dr. Badar Al habsi	

9 Related Documents

9.1 Appendix 1: Common Comorbidities:

9.2 Appendix 2: Non-pharmacological interventions

9.3 Appendix 3: Medication dosing

9.4 Appendix 4: Monitoring of medications

9.5 Appendix 5: Audit tool

9.6 Appendix 6: Document Request Form

9.7 Appendix 7: Document Validation Checklist.

10 References

Title of book/journal/articles/ Website	Author	Year of Publication	Page
ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of children and adolescents with attention-deficit/hyperactivity disorder	American Academy of Paediatrics, Subcommittee on Children and Adolescents with Attention-Deficit/Hyperactivity Disorder.	2019.	-
The ICD-10 Classification of Mental and Behavioural Disorders Clinical descriptions and diagnostic guidelines	World Health Organization	-	
Attention deficit hyperactivity disorder: diagnosis and management	www.nice.org.uk/guidance/ng87 NICE guideline Published	2018	
Taking Charge of ADHD: The Complete Authoritative Guide for Parents, 3rd Edition	Russell A. Barkley, Ph.D.	2005	
"Raising Resilient Children: Fostering Strength, Hope and Optimism in Your Child	Robert Brooks, Ph.D. and Sam Goldstein, Ph.D.	2002	
Attention Deficit Disorder: The Unfocused Mind in Children and Adults"	Tom Brown, Ph.D.	2006	
"Delivered from Distraction: Getting the Most Out of Life with ADHD	Edward M. Halowell, M.D. and John J. Ratey, M.D.	2005	
"Teenagers with ADD: A Parent's Guide"	Chris Zeigler Dendy, M.S.	1995	

"You Mean I'm Not Lazy, Stupid, or Crazy?"	Kate Kelly and Peggy Ramundo Books	2006	
"Learning to Slow Down & Pay Attention: A Book for Kids about ADHD	Kathleen Nadeau, Ph.D., Ellen Dixon, Ph.D., and Charles Beyl	2004	

11 Appendices

11.1Appendix 1.Common Comorbidities:

A. Psychiatric comorbidity

1. Oppositional defiant disorder

OVERLAPPING SYMPTOMS WITH ADHD CHARACTERISTICS	ODD DISTINCT
Loses temper Angry, resentful Touchy, easily annoyed Argumentative vindictive	Refuses to comply with rules Deliberately annoys others Blames others for their own mistakes Spiteful,

2. Conduct Disorder Differentiation

OVERLAPPING SYMPTOMS WITH ADHD	CD DISTINCT CHARACTERISTICS
Impulsively starts fights as a reaction to provocation	Instigates fights and may use weapons
May be rough with animals/ people due to lack of self-control	Takes pleasure in cruelty to animals and/or people
Forgets curfew	Disobeys curfew and runs away to engage in preferred activities without regard to consequences
Sets fire without considering consequences	Sets fires with vengeance
Steals impulsively	Steals with confrontation (planned)
Lies impulsively to avoid consequences	Lies to manipulate others and obtain gain
Breaks things accidently or impulsively	Vandalizes

3. Bipolar Affective Disorder Differentiation

Symptom	Bipolar disorder	ADHD
Euphoria	Excessive	Appropriate to situations
Irritability	Severe and intense	often Occasional, may be caused accompanied by tantrums by medication "wear-off"
Self-esteem	Grandiose	Demoralized
Sleep patterns	Decreased need for sleep	Difficulty settling at night
Speech patterns	Pressured, fragmented, Energetic and quick with flight of ideas	Energetic and quick
Thought processes	Racing thoughts Psychosis can occur at times	Patients do not report
Attention	Distractible	Distractible
Activity level	High energy, on-the-go, multiple projects, creative High-risk behaviors	Impulsive Hyperactive, multiple projects
Disruptive behaviors	Can become aggressive	Intrusive and active

4. **Borderline Personality Disorder Differentiation**

OVERLAPPING OF BPD SYMPTOMS WITH ADHD	**BPD DISTINCT CHARACTERISTICS**
Pattern of relationship challenges/impairments	Has intense relationships with often 'black and white' reactions and underlying intense fear of abandonment
Impulsivity and risky behaviour (e.g. gambling, reckless driving, unsafe sex, spending sprees, binge-eating or drug abuse)	Rapid changes in self-identity and self-image
Mood swings	Periods of stress-related paranoia and loss of contact with reality
Inappropriate and intense anger	Suicidal threats, behaviours or self-injury
	Ongoing feelings of emptiness

5. **-Anxiety Disorder Differentiation**

ADHD DISTINCT CHARACTERISTICS	**ANXIETY DISTINCT CHARACTERISTICS**
Inattentive symptoms independent of emotional state	Inattentive symptoms when anxious
Fidgetiness independent of emotional state	Fidgetiness while anxious
Social disinhibition	Social inhibition
Initial insomnia because of a difficulty to 'turn their thoughts	Initial insomnia because of ruminations

off'	or other anxiety symptoms
No subjective physical symptoms	Physical symptoms such as pounding heart, nausea, difficulty breathing, tremulousness
Transient and realistic worries related to prior and actual functional impairment (e.g. performance anxiety)	Persistent cognitive symptoms of intense fear and/or worry focused on unrealistic specific situations or thoughts

6. **Major Depressive Disorder Differentiation**

OVERLAPPING SYMPTOMS WITH ADHD	**DEPRESSION DISTINCT CHARACTERISTICS**
Loss of motivation, demoralization	Feeling sad or hopeless
Problems concentrating	Feeling tired or "slowed down"
Being restless or irritable	Changes in eating and/or sleeping, neuro vegetative symptoms
	Thoughts of death or suicide
	Episodic (while ADHD has a continuous course since childhood)

7. **Comparison of ADHD and Autism Spectrum Disorder (ASD) Distinct Features**

	ADHD Distinct Characteristics	**ASD Distinct Characteristics**
Age of Diagnosis	Usually 6-7 years old and older	Can be as early as 2-3 years old
Language	Not delayed No echolalia	Delayed Echolalia
Eye Contact	Less eye contact as eyes frequently shift focus	Avoids eye contact
Social Interests	More social in play	Less social in play
Friendships	Ostracized for impulsive behaviour, inattentive to other's states of mind, drawn to impulsive peers	Not interested in peers, 'parallel play' predominant, difficulty in understanding other's state of mind
Motor	Hyperactivity, "always on the go"	Rhythmic, stereotyped movements

B. **Medical comorbidity:**

- Hearing or vision Impairment
- Thyroid dysfunction
- Hypoglycaemia
- Severe anaemia
- Lead poisoning
- Sleep disorders
- Fatal Alcohol Spectrum Disorder (FASD)
- Medications that may have psychomotor side effects:
- Medication with cognitive dulling side effect (e.g. mood stabilizers).

- Medication with psychomotor activation (e.g. decongestants, beta-agonist like asthma medication)

C. SPECIAL PRESENTATIONS

Intellectual Giftedness

Research has shown that having a high IQ does not preclude the possibility that one might have ADHD. However, the co-occurrence of ADHD and intellectual giftedness remains controversial and under-investigated. Most previous discussions in the literature have been based largely on anecdotal comments, opinions and small clinical samples. Moreover, DSM-5 does not mention ADHD in the context of intellectual giftedness

Misdiagnosis of ADHD in the context of intellectual giftedness can occur in two ways: intellectually gifted individuals with high energy and over-excitability in school contexts (particularly in those with little academic stimulation) may be misdiagnosed as having ADHD; alternatively, intellectually gifted individuals who meet full diagnostic criteria for ADHD but who can concentrate for long periods of time, may not be diagnosed with ADHD.

Moreover, intellectually gifted individuals with ADHD may also meet criteria for SLD and other comorbidities. Thus, it is important for practitioners to recognize that intellectual giftedness in individuals with ADHD should be documented.

A high IQ may help individuals with ADHD cope with symptoms, and, therefore, in some cases clinically relevant impairment among gifted IQ children may not develop until later in elementary school or even in high school

Although ADHD may not be diagnosed until later it is not any less impairing. Diagnosis and treatment is critical at any age.

11.2Appendix (2): Non-pharmacological interventions.

11.2.1 Parent Training in Behaviour Management for ADHD

11.2.1.1 Behaviour therapy is an effective treatment for attention-deficit/hyperactivity disorder (ADHD) that can improve a child's behaviour, self-control, and self-esteem.

11.2.1.2 It is most effective in young children when it is delivered by parents. Experts recommend that healthcare providers refer parents of children younger than 12 years old for training in behaviour therapy.

11.2.1.3 For children younger than 6 years old, parent training in behaviour management should be tried before prescribing ADHD medication.

11.2.1.4 When parents become trained in behaviour therapy, they learn skills and strategies to help their child with ADHD succeed at school, at home, and in relationships.

11.2.1.5 Learning and practicing behaviour therapy requires time and effort, but it has lasting benefits for the child and the family.

11.2.1.6 Parents have the greatest influence on their young child's behaviour. Only therapy that focuses on training parents is recommended for young children with ADHD because young children are not mature enough to change their own behaviour without their parents' help.

11.2.1.7 Some therapists may use play therapy or talk therapy to treat young children with ADHD. Play therapy provides a way for children to communicate their experiences and feelings through play. Talk therapy uses verbal communication between the child and a therapist to treat mental and emotional disorders. Neither of these has been proven to improve symptoms in young children with ADHD.

11.2.1.8 **The parenting training should include the following:**

11.2.1.8.1 Teach parents skills and strategies that use positive reinforcement, structure, and consistent discipline to manage their child's behaviour.

11.2.1.8.2 Teach parents positive ways to interact and communicate with their child.

11.2.1.8.3 Assign activities for parents to practice with their child.

11.2.1.8.4 Meet regularly with the family to monitor progress and provide coaching and support.

11.2.1.8.5 Re-evaluate treatment plans and remain flexible enough to adjust strategies as needed.

11.2.2 <u>Behavioural classroom interventions (if available).</u>

11.2.2.1 Helping children adjust to changes in school

11.2.2.2 Children with attention-deficit/hyperactivity disorder (ADHD) experience more obstacles in their path to success than the average student. The symptoms of ADHD, such as inability to pay attention, difficulty sitting still, and difficulty controlling impulses, can make it hard for children with this diagnosis to do well in school.

11.2.2.3 To meet the needs of children with ADHD, schools may offer

11.2.2.3.1 ADHD treatments, such as behavioural classroom management or organizational training;

11.2.2.3.2 Special education services; or

11.2.2.3.3 Accommodations to lessen the effect of ADHD on their learning.

11.2.2.4 Classroom Treatment Strategies for ADHD Students

11.2.2.4.1 There are some school-based management strategies shown to be effective for ADHD students: behavioural classroom management and organizational training.

11.2.2.4.2 ***The behavioural classroom management*** approach encourages a student's positive behaviors in the classroom, through a reward systems or a daily report card, and discourages their negative behaviours. This teacher-led approach has been shown to influence student behaviour in a constructive manner, increasing academic engagement. Although tested mostly in elementary schools, behavioural classroom management has been shown to work students of all ages

11.2.2.4.3 ***Organizational training*** teaches children time management, planning skills, and ways to keep school materials organized in order to optimize student learning and reduce distractions. This management strategy has been tested with children and adolescents.

11.2.2.4.4 These two management strategies require trained staff—including teachers, counsellors, or school psychologists—follow a specific plan to teach and support positive behaviour.

11.2.2.5 **Special Education Services and Accommodations**

11.2.2.5.1 Most children with ADHD receive some school services, such as special education services and accommodations.

11.2.2.5.2 The support a child with ADHD receives at school will depend on if they meet the eligibility requirements for Ministry of Education special education services at the school.

11.2.2.6. **Accommodations**

11.2.2.6.1 To help the child with ADHD with school performance

11.2.2.6.2 Extra time on tests;

11.2.2.6.3 Instruction and assignments tailored to the child;

11.2.2.6.4 Positive reinforcement and feedback;

11.2.2.6.5 Using technology to assist with tasks;

11.2.2.6.6 Allowing breaks or time to move around;

11.2.2.6.7 Changes to the environment to limit distraction; and

11.2.2.6.8 Extra help with staying organized.

11.2.2.7 **What Teachers Can Do To Help**

11.2.2.7.1 For teachers, helping children manage their ADHD symptoms can present a challenge. Most children with ADHD are not enrolled in special education classes, but do need extra assistance on a daily basis.

11.2.2.7.2 Here are some tips for classroom success.

11.2.2.7.2.1 **Communication**

11.2.2.7.2.1.1 Give frequent feedback and attention to positive behaviour;

11.2.2.7.2.1.2 Be sensitive to the influence of ADHD on emotions, such as self-esteem issues or difficulty regulating feelings;

11.2.2.7.2.1.3 Provide extra warnings before transitions and changes in routines; and

11.2.2.7.2.1.4 Understand that children with ADHD may become deeply absorbed in activities that interest them (hyper-focus) and may need extra assistance shifting their attention.

11.2.2.7.2.2 **Assignments and Tasks**

11.2.2.7.2.2.1 Make assignments clear—check with the student to see if they understand what they need to do;

11.2.2.7.2.2.2 Provide choices to show mastery (for example, let the student choose among written essay, oral report, online quiz, or hands-on project;

11.2.2.7.2.2.3 Make sure assignments are not long and repetitive. Shorter assignments that provide a little challenge without being too hard may work well;

11.2.2.7.2.2.4 Allow breaks—for children with ADHD, paying attention takes extra effort and can be very tiring;

11.2.2.7.2.2.5 Allow time to move and exercise;

11.2.2.7.2.2.6 Minimize distractions in the classroom; and

11.2.2.7.2.2.7 Use organizational tools, such as a homework folder, to limit the number of things the child has to track.

11.2.2.7.2.3 **Develop a Plan That Fits the Child**

11.2.2.7.2.3.1 Observe and talk with the student about what helps or distracts them (for example, fidget tools, limiting eye contact when listening, background music, or moving while learning can be beneficial or distracting depending on the child);

11.2.2.7.2.3.2 Communicate with parents on a regular basis; and

11.2.2.7.2.3.3 Involve the school counsellor or psychologist.

11.2.2.8 Close collaboration between the school, parents, and healthcare providers will help ensure the child gets the right support.

11.2.2.9 How to best advocate for your child

11.2.2.9.1 Parents will need to liaise with the school to support their children education.

11.2.2.9.2 Understand your child's diagnosis, how it impacts their education, and what can be done at home to help.

11.2.2.9.3 Understand your child's Education Plan. If you have questions, don't be afraid to ask.

11.2.2.9.4 Speak with your child's teacher.

11.2.2.9.5 When possible, obtain written documentation from teachers, administrators, or other professionals working with your child.

11.2.2.9.6 Play an active role in preparing your child's Education Plan.

11.2.2.9.7 Keep careful records, including written documentation, communication between home and school, progress reports, and evaluations.

11.2.2.9.8 Try to maintain a good working relationship with the school while being a strong advocate for your child.

11.2.2.9.9 Communicate any concerns you may have about your child's progress.

11.2.2.9.10 Encourage your child every day, and work with your child to create a system to help with homework and other school projects.

11.2.3 Dietary advice

11.2.3.1 Healthcare professionals should stress the value of a balanced diet, good nutrition and regular exercise for children, young people and adults with ADHD.

11.2.3.2 Do not advise elimination of artificial colouring and additives from the diet as a generally applicable treatment for children and young people with ADHD.

11.2.3.3 Ask about foods or drinks that appear to influence hyperactive behaviour as part of the clinical assessment of ADHD in children and young people, and:

11.2.3.3.1 if there is a clear link, advise parents or carers to keep a diary of food and drinks taken and ADHD behaviour

11.2.3.3.2 If the diary supports a relationship between specific foods and drinks and behaviour, offer referral to a dietitian

11.2.3.3.3 Ensure that further management (for example, specific dietary elimination) is jointly undertaken by the dietitian, mental health specialist or paediatrician, and the parent or carer and child or young person.

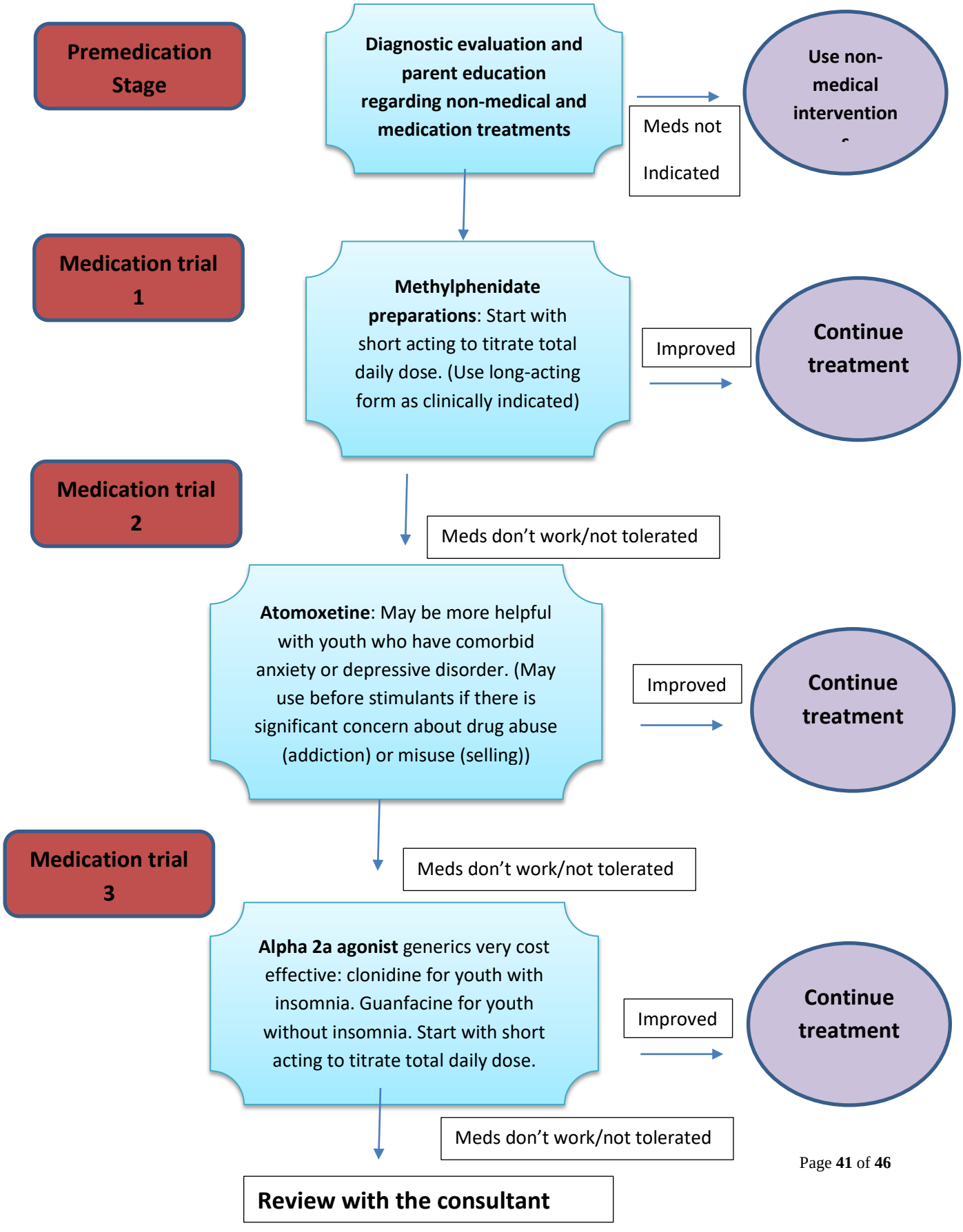
11.2.3.4 Do not advise or offer dietary fatty acid supplementation for treating ADHD in children and young people.

11.2.3.5 Advise the family members or carers of children with ADHD that there is no evidence about the long-term effectiveness or potential harms of a 'few food' diet for children with ADHD, and only limited evidence of short-term benefits.

11.3 Appendix (3): Medication dosing

Drug/Category Stimulants	Dosing/ Half-life	FDA Approval	Duration of Effects	Warnings/ Precautions
Methylphenidate Increased synaptic dopamine				
(**Ritalin**)	5 mg BID to TID Increase 5- 10mg increments up to 60 mg max. Estimated dose range .3-.6 mg/kg/dose	60mgs 6 years+	About 3-4 hours	Insomnia, decreased appetite, weight loss, retardation, headache, irritability, stomach-ache and rebound agitation
Ritalin SR	Start with 20 mg daily. May combine with short acting quicker onset	60mgs 6 years+	Onset in 30-60 minutes Duration about 8 hours	Same as above
Concerta 22% immediate release And 78% gradual release	Starting dose is 18 mg once daily, up to a max of 72 mg	daily 72 mg 6 years+	Onset in 60-90 minutes Duration 10-14 hours	Same as above but less rebound risk
Non-stimulant				
ATOMOXETINE Selective norepinephrine reuptake	Initiate at 0.5 mg/kg. The targeted clinical dose is 1.2 mg/kg, but titrate slowly at weekly intervals. Medication must be used each day	100 mgs 6 years+	Starts working within a few days to one week, but full effect may not be evident for a month or more. Duration of effect 24 hours	Decreased appetite, GI upset can be reduced if medication taken with food. Sedation can be reduced by dosing in evening. Light headedness. Risk of suicidal ideation and mania.

ALPHA-2 AGONISTS Increases norepinephrine via alpha-2				
Catapress	Starting dose is .025-.05 mg/day in evening. Increase dose every 5-7 days adding to morning and mid- day, possibly afternoon and again in evening dose sequence. Total dose 0.1-0.3 mg/day into 3-4 doses		Onset in 30-60minutes Duration about 3-6 hours	Sleepiness, hypotension, headache, dizziness, nightmares, Possible sever rebound hypertension if abruptly discontinued
Guanfacine (Tenex) Guanfacine XR (Intuniv) (guanfacine)	Starting dose is 0.5 mg/day in evening and Increase by similar dose every 7 days as indicated in divided doses 2-3 times per day. Daily dose range 0.5 4mg/day DO NOT skip days Intuniv is dosed once daily	Duration about 6- 12 hours	DO NOT skip days	


Premedication Stage
Diagnostic evaluation and parent education regarding non-medical and medication treatments
Meds not Indicated
Use non-medical intervention
Medication trial 1
Methylphenidate preparations: Start with short acting to titrate total daily dose. (Use long-acting form as clinically indicated)
Improved
Continue treatment
Medication trial 2
Meds don't work/not tolerated
Atomoxetine: May be more helpful with youth who have comorbid anxiety or depressive disorder. (May use before stimulants if there is significant concern about drug abuse (addiction) or misuse (selling))
Improved
Continue treatment
Medication trial 3
Meds don't work/not tolerated
Alpha 2a agonist generics very cost effective: clonidine for youth with insomnia. Guanfacine for youth without insomnia. Start with short acting to titrate total daily dose.
Improved
Continue treatment
Meds don't work/not tolerated
Review with the consultant

11.4 Appendix (4): Monitoring of medications

Height and weight

For people taking medication for ADHD:

- Measure height every 6 months in children and young people
- Measure weight every 3 months in children 10 years and under
- Measure weight at 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise
- Measure weight every 6 months in adults
- Plot height and weight of children and young people on a growth chart and ensure review by the healthcare professional responsible for treatment.
- If weight loss is a clinical concern, consider the following strategies:
    - taking medication either with or after food, rather than before meals
    - taking additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off
    - obtaining dietary advice
    - consuming high-calorie foods of good nutritional value
    - taking a planned break from treatment
    - Changing medication.
- If a child or young person's height over time is significantly affected by medication (that is, they have not met the height expected for their age), consider a planned break in treatment over school holidays to allow 'catch-up' growth. .

Cardiovascular

- Monitor heart rate and blood pressure and compare with the normal range for age before and after each dose change and every 6 months.
- Do not offer routine blood tests (including liver function tests) or ECGs to people taking medication for ADHD unless there is a clinical indication.
- If a person taking ADHD medication has sustained resting tachycardia (more than 120 beats per minute), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on 2 occasions, reduce their dose and refer them to a paediatric hypertension specialist or adult physician.
- If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes, reduce their dose or switch to another ADHD medication.

Tics

If a person taking stimulants develops tics, think about whether:

- The tics are related to the stimulant (tics naturally wax and wane) and
- The impairment associated with the tics outweighs the benefits of ADHD treatment.

If tics are stimulant related, reduce the stimulant dose, or consider changing to guanfacine (in children aged 5 years and over and young people only), atomoxetine (off-label use for adults with no ADHD symptoms in childhood), clonidine (off-label use for children), or stopping medication. Clonidine should only be considered for people under 18 years after advice from a tertiary ADHD service.

Seizures

If a person with ADHD develops new seizures or a worsening of existing seizures, review their ADHD medication and stop any medication that might be contributing to the seizures. After investigation, cautiously reintroduce ADHD medication if it is unlikely to be the cause of the seizures.

Sleep

Monitor changes in sleep pattern (for example, with a sleep diary) and adjust medication accordingly.

Worsening behaviour

Monitor the behavioural response to medication, and if behaviour worsens adjust medication and review the diagnosis.

Stimulant diversion

Healthcare professionals and parents or carers should monitor changes in the potential for stimulant misuse and diversion

11.5.Appendix 5. Audit Tool

Department: _____ **Date: _____**

S.N	Audit process	Standard / Criteria	Yes	Partial	No	N/A	Comment
1.	Interview	Does health care provider are aware about ADHD gidline					
3.	Interview observation Document Review	Does doctor Take full history including all necessary information , Initial risk assessment for the patient withADHD, Mental state examination and Ensure full physical assessment carried out including necessary investigation.					
4.	Interview Document Review	Dose the psychiatrist's implementation of a management/care plan appropriate to the risk factor identified.					
5	Document Review	Dose the doctor provisional diagnosis and information of care plan including observation and treatment and referring the patient to other multidisciplinary team for assessment.					
6.	Interview	Dose the psychiatrists has knowledge about Treatment options for management of ADHD					
7	observation	Does assigned nurse took appropriate action to make the environment safe to promote the safety of service users/ patients.					
9	Interview observation Document Review	Does assigned nurse maximizing the level of functioning Assess the patient ability to carry out activities of daily living and promoting Social skills.					

11.5 Appendix **6: Document Request Form**

Document Request Form			
Section A: Completed by Document Requester			
1. Requester Details			
Name	Dr. Wahid Hassan	Date of Request	
Institute	Al-Masarra Hospital	Mobile	–
Department	CAPD	Email	–
The Purpose of Request			
☑ Develop New Document	☐ Modification of Document	☐ Cancelling of Document	
1. Document Information			
Document Title	Clinical Guideline for the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder		
Document Code	AMRH/CAPD/[illegible]/001/Vers.01		
Section B: Completed by Document Controller			
☑ Approved	☐ Cancelled	☐ Forward To:……..	
Comment and Recommendation: Proceed with the document			
Name	Kumooz Al Balushi	Date	Nov 2022
Signature		Stamp	

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11.6 Appendix 7. Document Validation Checklist

Document Validation Checklist

Document Title: Clinical Guideline for the Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

Document Code: AMRH/CAPD/P&P/001/Vers.01

No	Criteria	Meets the Criteria			Comments
		Yes	No	N/A	
1.	**Approved format used**				
1.1	Clear title – Clear Applicability	✓			
1.2	Index number stated	✓			
1.3	Header/ Footer complete	✓			
1.4	Accurate page numbering	✓			
1.5	Involved departments contributed	✓			
1.6	Involved personnel signature /approval	✓			
1.7	Clear Stamp	✓			
2.	**Document Content**				
2.1	Clear purpose and scope	✓			
2.2	Clear definitions	✓			
2.3	Clear policy statements (if any)			✓	
3.	**Well defined procedures and steps**				
3.1	Procedures in orderly manner	✓			
3.2	Procedure define personnel to carry out step	✓			
3.3	Procedures define the use of relevant forms				
3.4	Procedures to define flowchart	✓		N/A	
3.5	Responsibilities are clearly defined	✓			
3.6	Necessary forms and equipment are listed	✓			
3.7	Forms are numbered	✓			
3.8	References are clearly stated	✓			
4.	**General Criteria**				
4.1	Policy is adherent to MOH rules and regulations	✓			
4.2	Policy within hospital/department scope	✓			
4.3	Relevant policies are reviewed	✓			
4.4	Items numbering is well outlined	✓			
4.5	Used of approved font type and size	✓			
4.6	Language is clear, understood and well structured	✓			

Recommendations ...✓..... For implementation ..... More revision ..... To be cancelled

Reviewed by:.....Kumar.....Al Balushi..... **Reviewed by:** Maria claudia Tajal

Guidelines

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