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| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| 1. POLICY STATEMENT   Winning Wheels, Inc. medical staff and/or contractual medical staff shall prescribe psychotropic drugs in accordance with following guidelines:  II. DEFINITIONS  "Psychotropic drugs" refer to drugs whose use for antipsychotic, antidepressant, antimanic and/or anti-anxiety purposes is listed in AMA Drug Evaluations, latest edition (American Medical Association) or Physician's Desk Reference latest edition (Medical Economics Company), Psychiatric Research Literature.  III. PROCEDURES   1. Alternatives to Drug Treatment:   Prior to the initiation of psychotropic medication, the treatment team shall consider, and discuss with the resident, or if the resident is under guardianship, the guardian, or if the resident is a minor, the resident's parent or guardian, as much as possible, alternative treatments, including their effectiveness, availability and risks. A behavior modification program will be indicated and implemented per individualized patient care plan(s) as appropriate.  B. Physician Examinations:  Each resident receiving psychotropic medication shall be individually examined by a physician as often as necessary but no less often than once every month. For a resident receiving antipsychotic medication this examination shall include an evaluation for signs of extrapyramidal symptoms.  C. Polypharmacy:  One antipsychotic agent in appropriate dose should be sufficient and more favorable for treatment of psychotic state. Since no antipsychotic agent is superior 'to any other in treating a psychotic state, if dosed properly (only side effects differ), the use of more than one antipsychotic may be inappropriate. | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  1 of 6 |

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| --- | --- | --- | --- | --- | --- |
| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| D. Adjusting Dosages:  1. The prescribing physician shall adjust the dose of a psychotropic drug to each individual resident's need. Since different residents may require different doses because of variability in metabolism and individual susceptibility to drugs, flexible dose strategies shall be employed to find the optimal dose for a given resident.  For most antipsychotic, antidepressant, and antimanic psychotropic medications, the therapeutic effect of a given dose is usually not observed for at least seven days.  2. Antipsychotic drug treatment shall be evaluated after reviewing past reduction history, the effects of such reductions, and with consideration of the benefits or risks of such reduction to the individual, by reducing the dose by about (10-25% every 60 to 90 days) until the drug has been stopped completely or the clinical condition worsens. This procedure indicates whether antipsychotic medication is still beneficial and also helps to detect signs of extrapyramidal symptoms upon withdrawal of the masking effect of the neuroleptic.  3. Reduction in dose shall be periodically considered for residents receiving medication for six months or longer.  E. Dosing Schedules:  1. Once-a-day or twice-a-day (B.I.D.) dosing is recommended for most psychotropic drugs, (or more often at physician's discretion). once-a-day or B.I.D. regimes have been shown to enhance resident compliance with medication taking.  2. For antipsychotic drugs, once-a-day dosing in the evening would:  a) maximally utilize sedative effects during the night, and may thus eliminate the need for prescription of sedative-hypnotics,  b) allow the resident to sleep through EPS activity thus reducing or eliminating the need for anti-cholinergic medication, and  c) may reduce daytime sedation. | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  2 of 6 |

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| --- | --- | --- | --- | --- | --- |
| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| F. Dosages and Treatment for all drugs:  1. Adequate doses shall be used to treat acute illnesses effectively.  2. Long-term medication shall be prescribed for residents if a significant potential for relapse is present and clinically indicated.  G. Dosages and Treatment for Antipsychotic Drugs:  1. Higher than the average acute treatment dose shall be considered for residents who are not adequately responding to lower doses.  2. The lowest effective dose shall be used for long-term treatment. Maintenance doses to prevent relapse shall be adjusted to the individual resident's need. The maintenance dose tp prevent relapse is usually 1/2 to 1/6 of the average daily acute treatment dose.  H. Average Acute Daily Treatment Dose and Daily Maximal Dose Limits For Psychotropic Druqs:     |  |  |  | | --- | --- | --- | | Psychotropic Drug | Daily Average Acute Treatment Dose (Milligrams) | Daily Maximal Dose Limit (Milligrams) | | Acetophenazine | 75-150 | 600 | | Alprazolam | .75-4 | 10 | | Amitriptyline | 150-200 | 350 | | Amoxapine | 150-300 | 600 | | Chlordiazepoxide | 15-100 | 300 | | Chlorpromazine | 100-800 | 2000 | | Chlorprothixene | 75-300 | 600 | | Chlorazepate | 15-60 | 60 | | Desipramine | 100-200 | 300 | | Diazepam | 4-40 | 40 | | Doxepin | 100-300 | 300 | | Fluphenazine\* | 10 | 100 | | Flurazepam | 15-30 | 60 | |  |  |  | | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  3 of 6 |

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| --- | --- | --- | --- | --- | --- |
| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| H. Average Acute Daily Treatment Dose and Daily Maximal Dose Limits For Psychotropic Drugs: (Cont'd)     |  |  |  | | --- | --- | --- | | Psychotropic Drug | Daily Average Acute Treatment Dose (Milligrams) | Daily Maximal Dose Limit (Milligrams) | | Halazepam | 80-160 | 160 | | Haloperidol\*\* | 12 | 120 | | Hydroxyzine Pamoate | 200-400 | 400 | | Imipramine | 100-200 | 350 | | Isocarboxazid | 20-30 | 30 | | Lithium |  |  | | Lorazepam | 2-6 | 10 | | Loxipine | 30-60 | 250 | | Maprotiline | 100-150 | 250 | | Meprobamate | 800-1600 | 2400 | | Mesoridazine | 200-400 | 500 | | Molindone | 50-100 | 225 | | Nortriptyline | 75-100 | 150 | | Oxazepam | 30-120 | 120 | | Perphenazine | 30-60 | 100 | | Phenelzine | 60-90 | 90 | | Pimozide | 1-10 | 20 | | Prazepam | 20-40 | 60 | | Prochlorperzine | 30-100 | 200 | | Protriptyline | 15-60 | 80 | | Temazepam | 15-30 | 60 | | Thioridazine | 400-800 | 800 | | Thiothixene | 20-40 | 150 | | Ttanylcypromine | 20 | 30 | | Trazodone | 75-500 | 600 | | Triazolam | .24-.5 | 1.5 | | Trifluoperazine | 20 | 100 | | Triflupromazine | 100-200 | 250 | | Trimipramine | 100-200 | 300 | | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  4 of 6 |

|  |  |  |  |  |  |
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| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| Flupherazine Enanihate or Decanoate - The average acute treatment dose is 6.25 to 50 mg every two weeks, and the maximal dose limit is 200 mg every two weeks.  Haloperidol Decanoate - The average acute treatment dose is 50 to 100 mg per month; maximal dose limit is 100 to 300 mg per month.  Lithium Carbonate shall be monitored by clinical effects and blood levels. Antimanic lithium blood levels should fall approximately in the range of 0.6-1.4 milliequivalents per liter (meq/1), and less than 1.6 meq/1. Since blood levels cannot be adjusted precisely, occasionally the suggested blood level may be exceeded. In this case, the oral dose should be adjusted downward to achieve blood levels within the recommended limits.  I. Use of List of Psychotropic Drugs:  1. Maximal Dose limit  a) Maximal dose limits specified on the list should not be exceeded except in extreme cases.  b) The maximal dose limit for anti-anxiety drugs is applicable to their use as anti-anxiety agents. When anti-anxiety drugs are used to treat acute alcohol and/or drug withdrawal, the dose shall be in accordance with the maximal dose recommended in the most recent edition of either AMA Drug Evaluations or Physician's Desk Reference whichever is greater.  2. It shall be the facility director's responsibility to ensure that there are adequate numbers of copies of the above-named publications tolmeet the needs of the facility staff.  J*.* Contingent Medication (short-term):  The casual (and at times regular) use of "PRN" for orders for psychotropic medication within facility shall be avoided. If a resident can be treated on a low dose with occasional use of contingent medication for acute exacerbation, this strategy is preferable to continuous higher dose therapy. When a physician wishes to address a resident's acute exacerbation of symptoms he/she shall consider ordering contingent (additional short-term) dosages of the psychotropic medication. The exact dose limits and specific contingent indication shall be documented in the medication orders of the individual resident.  a) Contingent medication orders for injections of psychotropic drugs used in emergency situations shall be for the same drug in the injectable form as the resident otherwise receives in the liquid or tablet form, unless no alternative injectable dosage form of the drug exists. | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  5 of 6 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PSYCHOTROPIC DRUGS | | | | NO. 222 | |
| b) If frequent contingent injectable medication is utilized in a week's time, the need for a higher maintenance dose of the medication shall be considered. This increase should be added to the regular dose of medication to arrive at the new maintenance dosage.  c) When ordering contingent (additional short-term) medication the physician shall state of Physician order form the specific medication to be used, dosage limits per administration, the frequency and route of administration, the maximum 24-hour limit, and the specific behavioral symptoms which the contingent medication is intended to influence.  K. Antiparkinsonian Medication:  Antiparkinsonian medication for extrapyramidal symptoms shall be given on a long-term basis only when clinically justified; a resident who needs antiparkinsonian medication early in his/her treatment of habilitation may not need this medication months later. Therefore, when medication in a treatment or habilitation-plan is reviewed, the prescribing physician shall consider whether or not the resident still needs antiparkinsonian medication. After four months of antiparkinsonian medication, it shall be gradually reduced (and eliminated) unless extrapyramidal symptoms persist or recur.  L. Long-Term Use of Sedative-Hypnotic Drugs:  The long-term use of sedative-hypnotic drugs shall be avoided. Whenever such drugs are prescribed for more than 30 days, the prescribing physician shall document the specific reason for such a prescription in the resident's medical record. | | | | | |
| Approved: | Effective Date: | Revision Date: | Change No.: | | Page:  6 of 6 |