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| ANTISPYCHOTIC DRUGS | | | | NO. | |
| PURPOSE:  To provide guidelines relating to the use of Antipsychotic Drugs.  STATEMENT OF POLICY:  It is the policy of this facility that residents who have not used antipsychotic drugs are not given these drugs unless it is necessary to treat to a specific condition as diagnosed and documented in the clinical record.  It is our policy that residents who use these drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  PROCEDURE:   1. **Procedure for evaluation the use of antipsychotic drugs.** 2. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following “specific conditions”; 3. Schizophrenia 4. Schizo-affective disorder 5. Delusional disorder 6. Psychotic mood disorders (including mania and depression with psychotic features) 7. Acute psychotic episodes 8. Brief reactive psychosis 9. Schizophreniform disorder 10. Atypical psychosis 11. Tourette’s disorder 12. Huntington’s disease 13. Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders) with associated psychotic and/or agitated behaviors: 14. Which have been quantitatively and objectively documented 15. Which are persistent 16. Which are not caused by preventable reasons 17. Which are causing the resident to: 18. Present a danger to himself/herself or to others 19. Continuously scream, yell or pace if these behaviors cause an impairment in functional capacity 20. Experience psychotic symptoms (hallucinations, paranoia, delusions) which cause the resident distress or impairment in functional capacity   12. Short term (7 days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. Treatment of nausea and vomiting secondary to cancer or chemotherapy may be longer. | | | | | |
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| 1. Antipsychotic drugs should not be used if one or more of the following is/are the ONLY indication for use:   Wandering  Poor self care  Restlessness  Impaired memory  Anxiety  Depression (without psychotic features)  Insomnia  Unsociability  Indifference to surroundings  Fidgeting  Nervousness  Uncooperativeness  Agitated behaviors which do not represent danger to the resident or others  C. Examples of Antipsychotic Drugs listed below should not be used in excess of the listed doses for residents with organic mental syndromes unless higher doses (as evidenced by the resident’s response and/or the resident’s clinical record) are necessary to maintain or improve the resident’s functional status. The dose levels are not maximum doses. These levels are to establish a point at which the clinical circumstance requiring the higher dose should be explained by the facility.  **Antipsychotic Drugs:**  Daily Dosage for Residents with  Generic Brand Organic Mental Syndromes  Chlorpromazine (Thorazine) 75 mg/day  Promazine (Sparine) 105 mg/day  Triflupromazine (Vesprin) 20 mg/day  Chloricazine (Mellaril) 75 mg/day  Mesoridazine (Serantil) 25 mg/day  Acetophenazine (Tindal) 20 mg/day  Perphenazine (Trilafor) 8 mg/day  Fluphenazine (Prolixin, Permitil) 4 mg/day  Trifluoperazine (Stelazine) 8 mg/day  Chlorprothixene (Taractan) 75 mg/day  Thlothlxene (Navane) 7 mg/day  Haloperido (Haldol) 4 mg/day  Molindone (Noban) 10 mg/day  Loxapine (Loxitane) 10 mg/day | | | | | |
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| **Antipsychotic Drugs: (continued)**  Daily Dosage for Residents with  Generic Brand Organic Mental Syndromes  Clozapine (Clozaril) 50 mg/day  Prochlorperazine (Compazine) 10 mg/day  Rispericone (Risperdal) 2 mg/day  Olanzapine (Zyprexa) 10 mg/day  Quetiapine (Seroquel) 200 mg/day  1. Doses listed are DAILY doses, usually administered in divided doses, for residents with organic mental syndromes. Therapy should be initiated with lower doses and gradually increased, only if necessary.  2. When drugs from this category are used at higher doses, they may be considered unnecessary drugs as a result of excessive dose.  **II. Procedure for evaluating necessity of a Gradual Dose Reduction.**  A. A Gradual Dose Reduction is an attempt to taper the resident’s daily dose to determine if the resident’s symptoms can be controlled by a lower does or to determine if dose can be eliminated.  B. A resident receiving an antipsychotic drug must, unless clinically contraindicated, have a gradual dose reduction of the drug.  C. The resident should be under close supervision while Gradual Dose Reduction is occurring.  D. If the Gradual Dose Reduction causes an adverse effect, and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record.  E. The facility must provide “Behavioral Interventions” to modify the resident’s behavior or environment, including staff approaches to care, to accommodate the resident’s behavioral symptoms.  F. “Clinically contraindicated” means that the resident need not undergo a Gradual Dose Reduction or Behavioral Interventions if:  1. The resident has a “specific condition” (refer to Section I), which has been stabilized with a maintenance dose of the drug without significant side effects.  2. The resident has organic mental syndrome and has had a gradual dose reduction attempted TWICE in one year with documentation of failure in the clinical record.  3. The resident’s physician provides justification why the continued use of the drug and the dose is clinically appropriate to include:  a. diagnosis and description of symptoms  b. discussion of the differential psychiatric and medical diagnosis  c. justification of choice of treatment  d. discussion of why present dose is necessary  4. Documentation should be included in the clinical record, but not necessarily in the physician’s progress notes. | | | | | |
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| G. Evidence that would support using a drug outside the Guidelines, but in the best interest of the resident might include:  1. Physician’s note stating why the drug is clinically appropriate. (Must demonstrate that the physician has carefully considered the risk / benefit to the resident.)  2. Medical or psychiatric consultation that confirms the physician’s judgment.  3. Physician, Nursing, or other health professional documentation indicating that the resident is being monitored for adverse reactions of the drug therapy.  4. Documentation showing that previous attempts at dose reductions have been unsuccessful.  5. Documentation (including MDS documentation) showing improvement or maintenance of function while on the medication.  6. Documentation of evaluations of resident declines for evidence of drugs being the cause.  7. Documentation showing why the resident’s age, weight, or other factors would require a unique drug dose or duration.  **III. Documentation**  A. Information regarding the use of drugs in this category should be recorded in the following areas:  1. Resident Care Plan  2. Pharmacy Consultation Report  3. Physician and Nursing Progress Notes  4. QA Auditing Form  5. Behavior Documentation  ATTACHMENT:  Antipsychotic Drug Training | | | | | |
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