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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:

WanderingPoor self careRestlessnessImpaired memoryAnxietyDepression (without psychotic features)InsomniaUnsociabilityIndifference to surroundingsFidgetingNervousnessUncooperativenessAgitated behaviors which do not represent danger to the resident or othersC. 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 SyndromesChlorpromazine (Thorazine) 75 mg/dayPromazine (Sparine) 105 mg/dayTriflupromazine (Vesprin) 20 mg/dayChloricazine (Mellaril) 75 mg/dayMesoridazine (Serantil) 25 mg/dayAcetophenazine (Tindal) 20 mg/dayPerphenazine (Trilafor) 8 mg/dayFluphenazine (Prolixin, Permitil) 4 mg/dayTrifluoperazine (Stelazine) 8 mg/dayChlorprothixene (Taractan) 75 mg/dayThlothlxene (Navane) 7 mg/dayHaloperido (Haldol) 4 mg/dayMolindone (Noban) 10 mg/dayLoxapine (Loxitane) 10 mg/day |
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| **Antipsychotic Drugs: (continued)** Daily Dosage for Residents with Generic Brand Organic Mental SyndromesClozapine (Clozaril) 50 mg/dayProchlorperazine (Compazine) 10 mg/dayRispericone (Risperdal) 2 mg/dayOlanzapine (Zyprexa) 10 mg/day Quetiapine (Seroquel) 200 mg/day1. 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 necessary4. 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 Plan2. Pharmacy Consultation Report3. Physician and Nursing Progress Notes4. QA Auditing Form5. Behavior DocumentationATTACHMENT:Antipsychotic Drug Training |
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