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|  Medications-Antipsychotics  | NO.  |
| Purpose: To provide monitoring of Residents on Antipsychotic Medications.Statement: The facility will ensure that each resident’s entire medication regimen is managed and monitored to achieve the following goals:1. The medication regimen helps promote or maintain the resident’s highest practicable mental, physical, and psychosocial well being, as identified by the resident and /or representatives in collaboration with the attending physician and facility staff.
2. Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s assessed conditions.
3. Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medications.
4. Clinically significant adverse consequences are minimized.
5. The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptoms is assessed and prevented.

Procedure:1. The Charge Nurse will monitor all use of antipsychotic medications on the unit.
2. The care plan team will assess each resident’s use of antipsychotic medications with every scheduled resident assessment and significant change of condition.

 1. Monitoring and assessment of antipsychotic medications use includes ensuring that:
2. An antipsychotic medication is used only for the following conditions/diagnoses as documented in the record and as meets the definitions in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR) or subsequent editions:
3. Schizophrenia
4. Schizo-affective disorder
5. Delusional disorder
6. Mood disorders
7. Schizophreniform disorder
8. Psychosis NOS
9. Atypical psychosis
10. Brief psychotic disorder
11. Dementing illnesses with associated behavioral symptoms.
12. Medical illnesses or delirium with manic or psychotic symptoms and/or treatment-related psychosis or mania (e.g., thyrotoxicosis, neoplasms, high does steroids)
13. The clinical condition also meets at least one of the following criteria ( i. or ii. or iii.):
14. The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions (such as paranoia or grandiosity); OR
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|  Medications-Antipsychotics  | NO.  |
| 1. The behavioral symptoms present a danger to the resident or to others: OR
2. The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end-of-life, or crying); a significant decline in function; and/or substantial difficulty receiving care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown and infection).
3. The behavioral symptoms are:
4. Not due to a medical condition or problem ( e.g., headache or joint pain, or electrolyte imbalance, pneumonia, hypoxia, unrecognized hearing or visual impairment) that can be expected to improve or resolve as the underlying condition is treated; AND
5. Persistent or likely to reoccur without continued treatment; AND
6. Not sufficiently relieved by non-pharmacological interventions: AND
7. Not due to environmental stressors (e.g., alteration in the resident’s customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response, physical barriers) that can be addressed to improve the psychotic symptoms or maintain safety; AND
8. Not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses) that can be expected to improve or resolve as the situation is addressed.
9. Within the first year in which a resident is admitted on an antipsychotic medication or has been started on an antipsychotic medication, the Charge Nurse must request that the resident’s physician evaluate the resident for Gradual Dose Reduction (GDR).
10. The request for GDR evaluation must be made in two separate quarters of the year, (with at least one month between the attempts), unless clinically contraindicated.
11. After the first year, the GDR evaluation must be requested annually, unless clinically contraindicated.
12. The Charge Nurse must document every request and the physician’s response in the resident’s chart.
13. The GDR may be considered clinically contraindicated if:a. The resident’s target symptoms returned or worsened after the most recent attempt at a GDR within the facility; AND

b. The physician has documented why any additional attempted dose reduction at that time would be likely to impair the resident’s function or increase distressed behavior.  |
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|  Medications-Antipsychotics  | NO.  |
| 1. In many situations, antipsychotic medications are not indicated. They should not be used if the only indication is one or more of the following.
2. Wandering
3. Poor self-care
4. Restlessness
5. Impaired memory
6. Mild anxiety
7. Insomnia
8. Unsociability
9. Inattention or indifference to surroundings
10. Fidgeting
11. Nervousness
12. Uncooperativeness
13. Verbal expressions or behavior that are not due to the conditions listed above and do not represent a danger to the resident or others.
14. Doses for acute indications (for example, delirium) may differ from those used for long-term treatment, but should be the lowest possible to achieve the desired therapeutic effects.
15. The Unit Nurse will:
16. Monitor the resident’s behavior every shift, and document observations in the resident’s record.
17. Administer the medication as ordered by the physician.
18. Use non-pharmacological interventions (such as behavioral interventions) when indicated, instead of, or in addition to, medication.
19. Monitor the resident every shift for signs and symptoms of adverse consequences of antipsychotic medication, and document in the resident’s record.
20. Notify the physician of signs and symptoms observed as needed.

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|  Medications-Antipsychotics  | NO.  |
| 1. Adverse consequences may include:
2. Akasthesia
3. Anticholinergic effects
4. Balance problem, unsteady gait, or fall
5. Blood sugar elevation (including diabetes mellitus)
6. Cardiac arrhythmias
7. Cerebrovascular event (e.g., stroke, transient ischemic attack) in older individuals with dementia
8. Dry Mouth
9. Dystonia
10. High Fever
11. Increase in total cholesterol and triglycerides
12. Lethargy or sedation
13. Muscle rigidity
14. Neuroleptic malignant syndrome (NMS)
15. Orthostatic hypotension
16. Parkinsonism
17. Restlessness
18. Tardive Dyskinesia
19. Tremors
20. Non-pharmacological interventions may include:
21. Comfort food
22. Companion
23. Decreased stimulation
24. Distraction
25. Exercise
26. Guided Imagery
27. Massage
28. Music
29. Positive reinforcement
30. Relaxation
31. Repositioning
32. Rest
33. Sleep
34. Spiritual activities
35. Television
36. Therapeutic conversation
37. Therapeutic environment
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|  Medications-Antipsychotics  | NO.  |
| 1. The MDS Nurse will:
2. Complete an Abnormal Involuntary Movement assessment (AIMS) and Fall Risk Assessment with each of the resident’s scheduled assessments and any significant change of condition.
3. Write and maintain a comprehensive plan of care for managing the resident’s use of antipsychotic medication that includes:
4. Monitoring for adverse consequences
5. Attempting gradual dose reductions
6. Non-pharmacological interventions
7. Behavioral, Psychosocial, and Mood care planning.
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