

PROBLEM: PSYCHOSIS		GOALS	APPROACHES
<p><u>Date</u></p> <p>Behavior (only one is required to be monitored, per Title XXII): <i>Either</i>:</p> <p>A. ___ new admission: currently assessing for behaviors. <i>Or</i>:</p> <p>B. ___ identified behaviors:</p> <p>1. _____</p> <p>2. _____</p> <p>Other behaviors (not monitored): _____</p> <p>II. Diagnosis (required):</p> <p>___ Atypical psychosis</p> <p>___ Bipolar, mania</p> <p>___ Brief psychotic disorder</p> <p>___ Danger to self or to others</p> <p>___ Delirium or Medical illnesses or with manic or psychotic sx</p> <p>___ Delusional disorder</p> <p>___ Dementing illnesses with associated behavioral sx</p> <p>___ Depression with psychotic features</p> <p>___ Depression-major: treatment refractory</p> <p>___ Distress-inconsolable or persistent- fear, continuous yelling, screaming, crying)</p> <p>___ Distress associated with end-of-life, or a significant decline in function</p> <p>___ Psychosis NOS (incl paranoia)</p> <p>___ Schizophrenia</p> <p>___ Schizo-affective disorder</p> <p>___ Schizophreniform</p> <p>___ Substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown</p> <p>___ Hospice</p> <p>___ Other:</p> <p>III. This is a source of either:</p> <p>___ distress (overwhelming fear), or</p> <p>___ dysfunction (behavior interferes with resident's ability to enjoy or participate in activities, meals, ADLs, conversation....</p> <p>IV. Side effects identified and managed:</p>	<p>A. Behaviors will be identified by first care plan conference or a dosage reduction will be addressed</p> <p>B. 1. Resident will have less than _____ episodes per _____ (time frame).</p> <p>2. Resident will have less than _____ episodes per _____ (time frame).</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>The behavioral symptoms are:</p> <p>___ not due to a medical condition or that can be expected to improve or resolve as the underlying condition is treated;</p> <p>___ not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety;</p> <p>___ not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed</p> <p>The resident may experience side effects for either a minimal length of time or to a manageable degree which do not cause significant impairment. (risk:benefit statement)</p>	<p>___ Encourage resident to verbalize feelings.</p> <p>___ Explain all procedures to resident at a level which the resident can understand.</p> <p>___ Encourage relaxation techniques and methods: quiet environment, writing, reading, peer discussion, one on one with staff or family, breathing or physical exercises, cards, games,</p> <p>___ Assess for exacerbating factors i.e. pain, insomnia, over-stimulation, life's situation</p> <p>___ Psychology/ counseling/ psychiatry/ social service referral.</p> <p>___ Antipsychotic medication per MD order</p> <p>___ Monitor for effectiveness of medication and report to MD monthly and as needed.</p> <p>___ Monitor for side effects in nursing notes and report to MD as needed.</p> <hr/> <hr/> <hr/> <hr/> <hr/> <p>Medication and Side Effects</p> <p>Medications: Abilify, Clozaril, Compazine, Geodon, Haldol, Inapsine, Invega, Loxitane, Mellaril, Navane, Phenergan, Prolixin, Risperdal, Serentil, Seroquel, Sparine, Stelazine, Thorazine, Trilafon, Zyprexa.</p> <p>Side effects: Parkinsonism - resting tremor, mask-like facies, shuffling gait, drooling, slowness of movement, lack of arm swing, pill-rolling, lead-pipe or cogwheel rigidity, balance disturbances, a "running" walk,</p> <p><i>Akinesia</i> - lack or poverty of movement</p> <p><i>Akathisia</i> - inability to remain still, constant movement or fidgeting, insomnia, "inner anxiety"</p> <p><i>Dyskinesia</i> - jerking or spastic movement of the arm, eye, face, leg, neck, or torso</p> <p><i>Dystonia</i> - altered posture, shift in body alignment</p> <p><i>Opisthonus</i> - spasms of the back muscles causing bending of the torso, often painful</p> <p>Black-Box Warning- All antipsychotics: Increased Mortality in Elderly Patients With Dementia-Related Psychosis: Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Atypical antipsychotics are not approved for the treatment of patients with dementia-related diagnosis.</p> <p>Black-Box Warning: Mellaril: Dose-related QTc interval prolongation (torsade de pointes). Reserve for patients with unacceptable responses to other antipsychotic drugs.</p>	
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PROBLEM: DEPRESSION		GOALS	APPROACHES
<p><u>Date</u></p> <p>Behavior (only one is required to be monitored, per Title XXII): Either: B. ____ new admission: currently assessing for behaviors. Or: B. ____ identified behaviors:</p> <p>1. _____ 2. _____</p> <p>Other behaviors (not monitored): _____ _____</p> <p>II. Diagnosis (required): ____ Adjustment disorder ____ Anxiety ____ Atypical Depression ____ Borderline Personality Dx ____ Bipolar ____ Bipolarity in Dementia ____ Depression–Mild<->Severe ____ Depressive Disorder–Major ____ Depressive w/ Psychotic ____ Depression-Recurrent ____ Histrionic Personality Dx ____ Mood Disorder ____ Obsessive-Compulsive ____ Panic Disorder ____ Phobia ____ Post-Traumatic Stress Dx ____ Schizoaffective ____ Sleep Disorder due to Medical Condition ____ Sleep Terror Disorder ____ Social Phobias ____ Somatization Disorder</p> <p>IV. Side effects identified and managed: _____ _____</p>	<p>A.. Behaviors will be identified by first care plan conference or a dosage reduction will be addressed</p> <p>B.-1. Resident will have less than ____ episodes per _____ (time frame).</p> <p>2. Resident will have less than ____ episodes per _____ (time frame).</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>The behavioral symptoms are:</p> <p>____ not due to a medical condition or that can be expected to improve or resolve as the underlying condition is treated;</p> <p>____ not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety;</p> <p>____ not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed</p> <p>The resident may experience side effects for either a minimal length of time or to a manageable degree which do not cause significant impairment. (risk:benefit statement)</p>	<p>____ Encourage to verbalize feelings. ____ Explain all procedures to resident at a level which the resident can understand. ____ Encourage relaxation techniques and methods: quiet environment, writing, reading, peer discussion, one on one with staff or family, breathing or physical exercises, cards, games, ____ Assess for exacerbating factors i.e. pain, insomnia, over-stimulation, life's situation ____ Psychology/ counseling/ psychiatry /social service referral. ____ Antidepressant medication per MD order ____ Monitor for effectiveness of medication and report to MD monthly ____ Monitor for side effects, document in nursing notes and report to MD ____ Depression assessment scale(name) _____ Result:____ Goal: ____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Medications and Side Effects SSRIs: Celexa, Lexapro, Luvox, Paxil, Prozac, Zoloft Side effects: excitement, nervousness, anxiety, tremor, sweating, dizziness, lightheadedness, anorexia, nausea, initial and withdrawal weight loss, long-term weight gain, seizure SNRIs: Cymbalta, Effexor; Others: Desyrel; Remeron; Wellbutrin; Side effects: headache, nervousness, somnolence, insomnia, anorexia, diaphoresis, dry mouth, constipation, somnolence, increased appetite, dry mouth, myalgia, edema, dyspnea, constipation, seizures, sedation, tachycardia, auditory disturbances Constipation, nausea, anorexia, vomiting, weight loss or gain, diaphoresis Cyclic: Adapin*, Anafranil*, Asendin, Aventyl, Elavil*, Etrafon, Limbitrol, Ludiomil, Norpramin, Pamelor, Pertofrane, Sinequan*, Surmontil, Tofranil*, Triavil, Vivactil Side effects: anticholinergic (dry mouth, blurred vision, urinary retention, constipation, confusion, sedation, tachycardia, postural hypotension, seizure Medications and Side Effects (cont.) MAOI: Emsam, Marplan, Nardil, Parnate Side effects: hypertensive crisis (tyramine interaction – chianti wine, aged cheeses and, soy sauce, sour cream, chocolate, sausages, dried fish, avocados, bananas, yeast, alcohol, caffeine, sympathomimetics Stimulant: Adderall, Cylert, Dexedrine, Provigil, Ritalin Side effects: excitement, wakefulness, tachycardia, insomnia, nervousness, drowsiness, stomach pain, suicidal ideation</p> <p>Black Box Warning: Increased risk of suicidal thinking and behavior in persons under 25 years of age and decreased suicide risk > 65 years of age Ritalin: caution if drug dependence or alcoholism hx; chronic abuse can lead to marked tolerance and psychological dependence w/ varying degrees abnormal behavior; frank psychotic episodes can occur, especially w/ parenteral abuse; careful supervision during withdrawal, severe depression may occur; withdrawal after chronic use may unmask underlying disorder sx requiring follow-up</p>	
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PROBLEM: ANXIETY		GOALS	APPROACHES
<p><u>Date</u></p> <p>Behavior (only one is required to be monitored, per Title XXII): <i>Either:</i> C. ___ new admission: currently assessing for behaviors. <i>Or:</i> B. ___ identified behaviors: 1. _____ 2. _____ Other behaviors (not monitored): _____ _____</p> <p>II. Diagnosis (required): ___ Acute alcohol or benzodiazepine withdrawal ___ Acute stress disorder ___ Agoraphobia ___ Anxiety -generalized, social or situational ___ Anxiety – symptomatic that occurs in residents w another diagnosed psychiatric disorder ___ Delirium ___ Dementia (OMS, OBS) with behaviors which cause distress or dysfunction ___ Obsessive-Compulsive dx ___ Panic disorder ___ Phobia – simple ___ Post-Traumatic disorder ___ Hospice ___ Other:</p> <p>III. This is a source of either: ___ distress (overwhelming fear), or ___ dysfunction (behavior interferes with resident's ability to enjoy or participate in activities, meals, ADLs, conversation....</p> <p>IV. Side effects identified and managed:</p>	<p>A. Behaviors will be identified by first care plan conference or a dosage reduction will be addressed B. 1. Resident will have less than _____ episodes per _____ (time frame). 2. Resident will have less than _____ episodes per _____ (time frame). _____ _____ _____ _____</p> <p>The behavioral symptoms are: ___ not due to a medical condition or that can be expected to improve or resolve as the underlying condition is treated; ___ not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety; ___ not due to psychological stressors (e.g., loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed</p> <p>The resident may experience side effects for either a minimal length of time or to a manageable degree which do not cause significant impairment. (risk:benefit statement)</p>	<p>Encourage resident to verbalize feelings. ___ Explain all procedures to resident at a level which the resident can understand. ___ Encourage relaxation techniques and methods: quiet environment, writing, reading, peer discussion, one on one with staff or family, breathing or physical exercises, cards, games, ___ Assess for exacerbating factors i.e. pain, insomnia, over-stimulation, life's situation ___ Psychology / counseling/ psychiatry/ social service referral. ___ Anxiolytic medication per MD order ___ Monitor for effectiveness of medication. Report to MD monthly and as needed. ___ Monitor for side effects in nursing notes and report to MD as needed.</p> <p>_____ _____ _____ _____ _____</p> <p><u>Medications and Side Effects</u></p> <p><u>Antihistamines:</u> Atarax*, Benadryl*, Vistaril* Side effects: confusion, dry mouth/eyes, blurred vision, constipation, urinary retention <u>Anxiolytics:</u> Ativan, Buspar, Klonopin*, Librium*, Serax, Tranxene*, Valium*, Xanax Side effects: confusion, sedation, muscular incoordination, tremors, drowsiness, slurred speech, headache, incontinence, falls, excitation, ataxia, tolerance (addiction), postural hypotension <u>Antidepressants + SSRIs:</u> Asendin, Celexa, Desyrel, Effexor, Luvox, Paxil, Prozac, Remeron, Wellbutrin, Zoloft Side effects: excitement, nervousness, anxiety, tremor, sweating, dizziness, lightheadedness, anorexia, nausea, initial and withdrawal weight loss, long-term weight gain, seizure, anticholinergic (dry mouth, blurred vision, urinary retention, constipation, confusion, sedation, tachycardia, postural hypotension, seizure</p> <p>* not recommended under OBRA for >65 years of age</p>	
RESIDENT:		MR	©2009 pacific point consultants 04/09

PROBLEM - INSOMNIA		GOALS	APPROACHES
Date	<p>Note: Complete #1 and #2.</p> <p>1. A. ___ The resident has been identified to have experienced a sleep disturbance.</p> <p>B. ___ The resident has been admitted with a hypnotic or the physician ordered medication without nursing assistance and: i. ___ there is a history of prior use. ii. ___ there is no history of prior use.</p> <p>C. ___ The resident with a dementia diagnosis has shown signs of a sleep disturbance which interferes with their ability to obtain a sufficient energy level, ability to focus, or attentiveness to participate in therapy, eating, visits, groups, or other activities of daily living.</p> <p>D. ___ The resident has a chronic use history which has been deemed by the physician to be safe, effective, and improving the resident's quality of life.</p> <p>E. ___ The resident has a diagnosis of dementia and the lack of nighttime sleep causes a dysfunction in the ability to enjoy activities, social interaction, eating, and an increase in behaviors</p> <p>2. Non-drug interventions: Either: A. ___ The resident IS or IS NOT (circle one) willing try non-drug Interventions. Or: B. ___ The resident has failed non-drug interventions.</p>	<p>A. To provide the resident with the opportunity to enjoy an optimum level of sleep with the minimum acceptable level of risks taking into consideration the resident's concomitant diagnoses and overriding need for rest during rehabilitation or convalescence.</p> <p>B. Interventions shall show some improvement in the resident's sleep disturbance as evidenced by ability to attend or participate in activities of daily living.</p> <p>C. The resident shall continue to receive the same benefit of sleep improvement already experiencing without clinically significant side effects.</p> <p>D. The resident shall continue to receive the same benefit of sleep improvement already experiencing without clinically significant side effects.</p> <p>E. The resident shall maintain the same level of quality of life as experienced when a full night sleep was obtained. The benefits of quality of life outweigh the risks of side effects. NOTE: Hypnotic orders, except antidepressants, should be on a PRN basis – exceptions must be supported with physician documentation of a risk/benefit statement.</p> <p>F. Review in 30 / 60 / 90 / ___ days. (circle one)</p>	<p>Non-medication interventions: ___ check for bowel / bladder needs ___ food / fluid needs ___ review noise level in the vicinity ___ rule out pain, offer pain medication ___ change positioning / get up from bed ___ touch therapy / massage ___ offer warm/cold towel / shower ___ discuss with resident realistic expectations regarding sleep quantity of hours and quality ___ discuss with resident issues of anxiety or depression</p> <p>Note: some interventions may be refused, partially effective or ineffective.</p> <p>___ The use of non-pharmacological Interventions continue to be evaluated in an attempt to assist in resolution of the sleep disturbance prior to or in addition to the use of hypnotic agents. ___ The use of non-pharmacological interventions are either partially or completely ineffective in resolving the sleep disturbance. ___ Medication is being limited to a short term basis (<1 month), though use may be more than twice a week. ___ Minimal use (no more than twice a week), as defined under OBRA, is being attempted. ___ A medication reduction attempt will begin after it has been determined the risk of a reduction will not negatively affect other more significant diagnoses or conditions.</p> <p>Reduction Program Either: ___ A reduction program is being undertaken since the resident is now medically stable. Or: ___ A slow reduction, due to the history of chronic use, is being undertaken since the resident is now medically stable. Or: ___ Maintenance therapy will continue since the physician has determined the benefits of continued therapy outweigh the risks of reduction.</p>
Resident:		Medical Record #:	©2009 pacific point consultants 04/09

