

PROBLEM: PSYCHOSIS		GOALS	APPROACHES
<p><u>Date</u></p> <p>Behavior (only one is required to be monitored, per Title XXII): Either: A. ___ 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): ___ Atypical psychosis ___ Bipolar, mania ___ Brief psychotic disorder ___ Danger to self or to others ___ Delirium or Medical illnesses or with manic or psychosis ___ Delusional disorder ___ Dementing illnesses with associated behavioral sx ___ Depression with psychotic features ___ Depression-major: treatment refractory ___ Distress-inconsolable or persistent- fear, continuous yelling, screaming, crying) ___ Distress associated with end-of-life, or a sig decline in function ___ Psychosis NOS (incl paranoia) ___ Schizophrenia ___ Schizo-affective disorder ___ Schizophreniform ___ Substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown ___ 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. ___ Antipsychotic medication per MD order ___ Monitor for effectiveness of medication and report to MD monthly and as needed. ___ 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. 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, <i>Akinesia</i> – lack or poverty of movement <i>Akathisia</i> - inability to remain still, constant movement or fidgeting, insomnia, "inner anxiety" <i>Dyskinesia</i> - jerking or spastic movement of the arm, eye, face, leg, neck, or torso <i>Dystonia</i> – altered posture, shift in body alignment <i>Opisthonous</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. 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.._____</p> <p>2. _____</p> <p>Other behaviors (not monitored):</p> <p>_____</p> <p>_____</p> <p>II. Diagnosis (required):</p> <p><input type="checkbox"/> Adjustment disorder</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Atypical Depression</p> <p><input type="checkbox"/> Borderline Personality Dx</p> <p><input type="checkbox"/> Bipolar</p> <p><input type="checkbox"/> Bipolarity in Dementia</p> <p><input type="checkbox"/> Depression–Mild<->Severe</p> <p><input type="checkbox"/> Depressive Disorder–Major</p> <p><input type="checkbox"/> Depressive w/ Psychotic</p> <p><input type="checkbox"/> Depression-Recurrent</p> <p><input type="checkbox"/> Histrionic Personality Dx</p> <p><input type="checkbox"/> Mood Disorder</p> <p><input type="checkbox"/> Obsessive-Compulsive</p> <p><input type="checkbox"/> Panic Disorder</p> <p><input type="checkbox"/> Phobia</p> <p><input type="checkbox"/> Post-Traumatic Stress Dx</p> <p><input type="checkbox"/> Schizoaffective</p> <p><input type="checkbox"/> Sleep Disorder due to Medical Condition</p> <p><input type="checkbox"/> Sleep Terror Disorder</p> <p><input type="checkbox"/> Social Phobias</p> <p><input type="checkbox"/> Somatization Disorder</p> <p>IV. Side effects identified and managed:</p> <p>_____</p> <p>_____</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><input type="checkbox"/> not due to a medical condition or that can be expected to improve or resolve as the underlying condition is treated;</p> <p><input type="checkbox"/> not due to environmental stressors that can be addressed to improve the psychotic symptoms or maintain safety;</p> <p><input type="checkbox"/> 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.</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>____ Antidepressant medication per MD order</p> <p>____ Monitor for effectiveness of medication and report to MD monthly</p> <p>____ Monitor for side effects, document in nursing notes and report to MD</p> <p>____ Depression assessment scale (name) _____ Result:____ Goal: ____</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): Either:</p> <p>C. ___ new admission: currently assessing for behaviors. Or:</p> <p>B. ___ identified behaviors:</p> <p>1. _____</p> <p>2. _____</p> <p>Other behaviors (not monitored):</p> <p>_____</p> <p>_____</p> <p>II. Diagnosis (required):</p> <p>___ Acute alcohol or benzodiazepine withdrawal</p> <p>___ Acute stress disorder</p> <p>___ Agoraphobia</p> <p>___ Anxiety -generalized, social or situational</p> <p>___ Anxiety – symptomatic that occurs in residents w another diagnosed psychiatric disorder</p> <p>___ Delirium</p> <p>___ Dementia (OMS, OBS) with behaviors which cause distress or dysfunction</p> <p>___ Obsessive-Compulsive dx</p> <p>___ Panic disorder</p> <p>___ Phobia – simple</p> <p>___ Post-Traumatic disorder</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>_____</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>___ Anxiolytic medication per MD order</p> <p>___ Monitor for effectiveness of medication.</p> <p>___ Report to MD monthly and as needed.</p> <p>___ Monitor for side effects in nursing notes and report to MD as needed.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Medications and Side Effects</p> <p>Antihistamines: Atarax*, Benadryl*, Vistaril*</p> <p>Side effects: confusion, dry mouth/eyes, blurred vision, constipation, urinary retention</p> <p>Anxiolytics: Ativan, Buspar, Klonopin*, Librium*, Serax, Tranxene*, Valium*, Xanax</p> <p>Side effects: confusion, sedation, muscular incoordination, tremors, drowsiness, slurred speech, headache, incontinence, falls, excitation, ataxia, tolerance (addiction), postural hypotension</p> <p>Antidepressants + SSRIs: Asendin, Celexa, Desyrel, Effexor, Luvox, Paxil, Prozac, Remeron, Wellbutrin, Zoloft</p> <p>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

