

Psychotropic Medication Use

“Psychotropic drug” is defined in the regulations at §483.45(c)(3), as “any drug that affects brain activities associated with mental processes and behavior.”
Psychotropic drugs include, but are not limited to the following categories: anti-psychotics, anti-depressants, anti-anxiety, and hypnotics.

PROBLEM/STRENGTH	GOALS	DUE DATE	APPROACHES	DISP RESP
<p>DX:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Injury, high risk for <input type="checkbox"/> Thought processes, altered <input type="checkbox"/> Psychotropic drug use <input type="checkbox"/> Tardive dyskinesia, potential for <p>As related to: (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Motor agitation <input type="checkbox"/> Poor balance <input type="checkbox"/> Syncope <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Agitation <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer’s <input type="checkbox"/> Alcohol withdrawal <input type="checkbox"/> Judgment deficit <input type="checkbox"/> Reasoning deficit <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Insomnia <input type="checkbox"/> Obsessive compulsive disorder <input type="checkbox"/> Post- traumatic stress disorder (PTSD) <input type="checkbox"/> Panic disorder <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Attention deficit disorder <input type="checkbox"/> Autism <input type="checkbox"/> Psychosocial adjustment difficulty <p>As evidenced by: (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Delirium <input type="checkbox"/> Delusions <input type="checkbox"/> Depression <input type="checkbox"/> Deterioration in behavior 	<ul style="list-style-type: none"> <input type="checkbox"/> Communicate appropriately with others by _____ <input type="checkbox"/> Resident’s dignity will be maintained _____ <input type="checkbox"/> Have reduction in number of medications requested by _____ <input type="checkbox"/> Have drug (name) _____ blood level within therapeutic range by _____ <input type="checkbox"/> Have drug (name) _____ blood level within specified range by _____ <input type="checkbox"/> Have no delusional thinking by _____ <input type="checkbox"/> Have no injury related to medication usage/side effects by _____ <input type="checkbox"/> Resident’s safety will be maintained _____ <input type="checkbox"/> Interact appropriately with others by _____ <input type="checkbox"/> Maintain normal/therapeutic blood drug range of _____ by _____ 		<ul style="list-style-type: none"> <input type="checkbox"/> Change frequency of (specify) _____ from _____ to _____ and monitor for effectiveness and side effects <input type="checkbox"/> Discuss side effects of drugs with resident and resident representative <input type="checkbox"/> Perform root cause analysis with IDT for mood and behavioral issues <input type="checkbox"/> Do not allow resident to walk without assistance of staff <input type="checkbox"/> Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs (GDR process) <input type="checkbox"/> Give resident opportunity to perform portions (specify) _____ of own ADLs <input type="checkbox"/> Instruct family/significant others to _____ <input type="checkbox"/> Monitor drug blood levels for (specify) _____ every _____ <input type="checkbox"/> Monitor interaction of resident with others for appropriateness <input type="checkbox"/> Monitor pharmacist’s drug regimen review for identification of potential drug interactions and irregularities <input type="checkbox"/> Monitor resident’s mental status functioning on ongoing basis <input type="checkbox"/> Monitor resident’s mood state <input type="checkbox"/> Monitor resident’s sleep patterns <input type="checkbox"/> Monitor hours of sleep <input type="checkbox"/> Observe for increased lethargy <input type="checkbox"/> Monitor of signs/symptoms of TD <input type="checkbox"/> Observe resident’s gait for steadiness, balance, muscle coordination, ability to position and turn <input type="checkbox"/> Offer resident opportunities to problem solve (reasoning) <input type="checkbox"/> Performs AIMS/DISCUS assessment 	

Resident: _____ MR#: _____ Room: _____

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PROBLEM/STRENGTH	GOALS	DUE DATE	APPROACHES	DISP RESP
<ul style="list-style-type: none"> <input type="checkbox"/> Deterioration in communication <input type="checkbox"/> Deterioration in intellectual function <input type="checkbox"/> Deterioration in mood <input type="checkbox"/> Dizziness <input type="checkbox"/> Dry mouth <input type="checkbox"/> Hallucinations <input type="checkbox"/> Hypotension <input type="checkbox"/> Incontinence <input type="checkbox"/> Involuntary movements of mouth, face, and so forth <input type="checkbox"/> Loss of ability to position <input type="checkbox"/> Loss of voluntary extremity movement <input type="checkbox"/> Marked decrease in spontaneous movements <input type="checkbox"/> Motor agitation <input type="checkbox"/> Muscular rigidity <input type="checkbox"/> Poor balance <input type="checkbox"/> Potential for drug toxicity <input type="checkbox"/> Potential for injury <input type="checkbox"/> Swallowing problem <input type="checkbox"/> Syncope <input type="checkbox"/> Tremors <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Urinary retention <input type="checkbox"/> Withdrawal <input type="checkbox"/> Cries frequently <input type="checkbox"/> Short term memory loss <input type="checkbox"/> Long term memory loss <input type="checkbox"/> Combative behavior <input type="checkbox"/> Verbally abusive <input type="checkbox"/> Abusive to self <input type="checkbox"/> Mistrust others <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Paranoia <input type="checkbox"/> Tardive Dyskinesia 	<ul style="list-style-type: none"> <input type="checkbox"/> Not show (specify) _____ as side effect of medication use by _____ <input type="checkbox"/> Show improved reasoning capacity by _____ <input type="checkbox"/> Show improvement in behavior by _____ <input type="checkbox"/> Show improvement in mood by _____ <input type="checkbox"/> Show minimal/no side effects of medications taken by _____ <input type="checkbox"/> Show no involuntary movements of mouth, face and so forth by _____ <input type="checkbox"/> Show no muscular rigidity in walking by _____ <input type="checkbox"/> Show no signs of hallucinating by _____ <input type="checkbox"/> Show no signs of tremors by _____ <input type="checkbox"/> Show progress toward normal/therapeutic blood range of _____ by _____ <input type="checkbox"/> Take medication(s) as ordered by _____ 		<ul style="list-style-type: none"> <input type="checkbox"/> Take and record pulse/respiration/blood pressure per protocol <input type="checkbox"/> Take blood pressure in lying position and then in sitting position every (frequency) _____ <input type="checkbox"/> Take blood pressure in sitting position and then in standing position every (frequency) _____ <input type="checkbox"/> Teach resident to _____ <input type="checkbox"/> Monitor for signs and symptoms of hypotension 	

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