



The Step Method Toward Titration or Discontinuance of Medication

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Societal concerns and the HCFA regulations regarding the utilization of psychotropic medications, particularly the “flagging” of the inappropriate use of PRN orders, has resulted in the immediate discontinuance of both routine and PRN orders for many residents using this class of medications. The time spent trying to stabilize and prevent the resident from decompensating could be better spent if the medication that is to be discontinued or reduced followed a flow sheet designed to prevent the withdrawal reactions.

Approximately 15 percent of older adults have functional psychiatric disturbances¹. Most of these older adults will be taking psychotropic medications when residing in long term care facilities. In

most cases, a resident’s drug regimen may include many medications that are not being taken care of regularly, thus these PRN medications may be discontinued immediately. (Provided that there are established behavior modification programs which will be used routinely, and consistently, as an intervention to these PRN orders.)

Almost any drug can have adverse effects in the older adult. Well defined clinical guidelines for the discontinuance of psychotropic drugs in the behaviorally disturbed elderly remain unclear. However, response to a psychotropic drug should be closely monitored. Lack of improvement in mental status, or behavior, in two months can be used as justification for the discontinuation of such drugs.

The use of “ratings scales” by nurses for anxiety, depression, agitation and abnormal involuntary movement disorders can effectively assess and monitor the effect of psychotropic medications and other interventions. Withdrawal of medications that affect

these disorders may be characterized by disturbances of sleep, perception of fatigue, hallucinations, severe depression, agitation and the development of abnormal involuntary movement syndromes. To prevent these disturbances, “go slow and go low” is well worth remembering.

To develop a flow sheet designed to minimize or eliminate withdrawal reactions, ideally a health care team should be developed that consists of a psychologist, consultant pharmacist, charge nurse and social worker. The team would cooperate with the attending physician and develop both a behavior modification program for the resident, and a flow sheet which will define, step by step, the tapering of the medication and the interventions that the staff will use if withdrawal symptoms or inappropriate behavior occurs.

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STEP TITRATION OF PSYCHOTROPIC MEDICATIONS

1. Assess resident using a specific behavioral assessment scale.
2. Establish baseline target behavior. For example, if the patient is screaming, determine how often it occurs. Repeat monitoring of inappropriate behaviors every seven days.
3. Medication changes will start with only one change in drug therapy at a time.
4. Choose a goal to be accomplished within a time frame. For example, the reduction of a neuroleptic by a specific number of milligrams within three months.
5. The dosage schedule should be as uncomplicated as possible.
6. The lowest dosage change will be initiated.
7. Titrate the dosage slowly down, usually after seven days.

8. Repeat the assessment scale every 14 days. If the assessment scale indicates improvement or no significant changes, and no withdrawal symptoms are present, continue to reduce medication. If there are withdrawal symptoms present, or the assessment scale indicates an escalation of symptoms over the baseline assessment, continue at the same dose for at least another seven days, then reassess. At this point, the health care team would have to decide whether continued titration would be beneficial to the resident in terms of a risk ratio.

There is agreement that the older adult should have minimum exposure to psychotropic medications and, certainly, there is less risk of adverse drug reactions when there is a minimum number of medications, at the lowest possible dose, present in the drug regimen. However, there are many studies indicating that there is a chemical basis for mental illness, and psychotropic medications which alter the levels of neuro hormones and mediators can positively affect the quality of life of the mentally ill older adult. To presuppose that psychotropic drugs are merely utilized as chemical restraints, in lieu of physical restraints, or to take the place of the care provided by a dedicated health care team because of staff shortages, is a simplistic overview to sophisticated therapeutic problems, not the least of which are diagnosis, underdose, overdose and tolerance.

¹ Carl Salsman, M.D. Geriatric Psychopharmacology

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