



# Psychotropic Medication Tracking Tool for Nursing Homes

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(Use with antipsychotic, antianxiety, and hypnotic medications)

<b>RESIDENT:</b>	<b>ROOM#:</b>	<b>DATE:</b>
Prescribing Clinician:		
Medication:	Dose:	Frequency:
Route:	Scheduled or PRN:	
Diagnosis/clinical rationale:		
Target behavior(s):		
Target behavior(s) observed w/in last 7 days:		
<p>Document the ongoing progress and/or possible causes of the target behavior(s). Include <b>who</b> was involved, <b>what</b> happened, <b>where</b> and <b>when</b> it occurred, <b>why</b> it possibly occurred, and <b>how</b> it affected the resident or others:</p> <hr/> <hr/> <hr/> <hr/> <hr/>		
<b>FACILITY PROCESSES</b>		
Is there documentation of an evaluation of possible environmental, medical, physical, emotional, social, functional or psychiatric causes or triggers of the resident's behavior?		<b>YES</b> <b>NO*</b>
Has pain been considered as a possible cause of behavior?		<b>YES</b> <b>NO*</b>
Have medications been considered as a possible cause of behavior?		<b>YES</b> <b>NO*</b>
Are there individualized, person-centered non-medication interventions and therapeutic approaches included in the care plan?		<b>YES</b> <b>NO*</b>
Are these interventions and approaches utilized by the staff?		<b>YES</b> <b>NO*</b>
<b><u>*If any of the above are answered NO, action is necessary to include these in resident's clinical record.</u></b>		
Notes on effectiveness of non-medication interventions and therapeutic approaches used:		
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<i>**Continued on other side**</i>		

Is there documentation of risk/benefit discussion with resident or legal representative when obtaining consent and interdisciplinary team before the initiation of medication? **YES** **NO\***

**\*If answered NO, action is necessary to include this in resident's clinical record.**

Describe any observed changes in the frequency/intensity of the primary target behavior(s) after medication was started:

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**CLINICAL MONITORING**

In the last six months has resident gone to the ER or Hospital secondary to target behavior? **YES** **NO**

Has the resident experienced adverse effects or functional decline due to medication? **YES** **NO**

If **YES**, describe: \_\_\_\_\_

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If started outside facility, is medication still necessary after individual has acclimated to the facility? **YES** **NO**

Has a gradual dosage reduction (GDR) been attempted in the last 3 months? **YES** **NO**

If **YES**, outcome of the GDR: \_\_\_\_\_

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If **NO**, is GDR appropriate at this time? **YES** **NO**

*(NOTE: GDR is recommended every three months when behavior frequency/intensity remains at a manageable level. Consult with prescribing physician.)*

If GDR is not appropriate, has physician documented a clinical explanation for maintaining the medication at the current dose? **YES** **NO**

*(NOTE: For residents with dementia, at least one attempt at GDR should be initiated within the facility unless behaviors are causing severe distress or harm to self or others.)*

Comments: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Name/Title/Credentials)