MANAGEMENT OF PSYCHOTHERAPEUTIC MEDICATION-INDUCED MOVEMENT DISORDER

1. **Purpose**: To establish guidelines for a collaborative process for systematically monitoring residents for potential abnormal involuntary movements resulting from the use of prescribed psychotherapeutic medications. The intent of these guidelines is to provide a monitoring system to obtain information for early detection of these involuntary movements and to help lessen their impact on the resident’s quality of life. There is no guaranteed treatment for Tardive Dyskinesia, and the following recommendations are:

   a. **Minimize causative factors**:
      
      (1) use psychotherapeutic medication only for clinically appropriate conditions;
      
      (2) monitor medication efficacy via objective data. Non–responders or minimal responders may have a higher risk of Tardive Dyskinesia than responders.

   b. **Early detection**:
      
      (1) use standardized assessment tools and examination procedures;
      
      (2) perform regular and systematic examinations for early detection, and
      
      (3) educate residents, families and staff about movement disorders as side effects of prescribed medications

   c. **Minimize impact when a Movement Disorder presents**;
      
      (1) reduce antipsychotic medication and discontinue if clinically possible (reduction may need to be gradual such as 10% to 25% every one to three months);
      
      (2) slowly reduce and discontinue anticholinergic medications if clinically possible. Due to potential anticholinergic withdrawal effects, this may need to be gradual over 2-6 weeks;
      
      (3) differentiate mild versus severe Tardive Dyskinesia and the impact of the symptoms on the resident’s functional status as a basis for auxiliary pharmacological intervention; and

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This Operating Procedure supersedes: Operating Procedure 155-24, dated February 21, 2007

Office of Primary Responsibility: Clinical Director

Distribution: Florida State Hospital Computer Network Users
(4) avoid antipsychotic medication dose increases to mask Tardive Dyskinesia unless a severe, cosmetically disfiguring, functionally debilitating, or life-threatening situation is present, or if clinically indicated.

2. **Scope**: Applies to all residents at Florida State Hospital.

3. **Training Requirements**: Physicians and Advanced Registered Nurse Practitioners will be trained on this operating procedure upon hire into the position during Discipline-Specific Education and by their supervisor each time the operating procedure is revised.

4. **References**:
   a. Drugs Facts and Comparisons.
   b. Florida State Hospital Operating Procedure 150-34, “Psychotherapeutic Medication Prescription Standards.”

5. **Definitions**:
   a. q (or Q)--every;
   b. qd (or QD or q.d.)--every day;
   c. BID (or b.i.d.)--twice daily;
   d. QID (or q.i.d.)--four times daily;
   e. IM--intramuscular;
   f. mg--milligram.

6. **Psychotherapeutic Medication-Induced Movement Disorders**: (For the purpose of this operating procedure, the words “neuroleptic” and “antipsychotic”; “psychotherapeutic” and “psychotropic” are used interchangeably.)
   a. Neuroleptic-Induced Parkinsonism/Pseudoparkinsonism--characterized primarily by a generalized slowing of movements and usually appear in a triad of: (1) rhythmic, resting tremor; (2) rigidity (stiffness/hypertonia or hypotonia or cogwheeling); and (3) bradykinesia/ slowness of voluntary movement (also called akinesia) and masked facial appearance. Clinical signs may include stooped posture, shuffling gait, drooling, tremors, pill rolling. Onset is usually early, within 5-30 days of medication initiation. Incidence is high, about 41%. Signs and symptoms
may be related to medication dosage and strength. Parkinsonism typically persists for months. Non-psychotropic medications, such as metoclopramide (Reglan), trimethobenzamine (Tigan), prochlorperazine (Compazine), and promethazine (Phenergan) can induce these abnormal involuntary movements.

Treatment: The benefits versus risks of prophylactic treatment remain controversial because of their side effects. However, once parkinsonian symptoms appear, the following are recommended: (a) reduce neuroleptic medication dosage, (b) start antixtarypyramidal system medications, and (c) change neuroleptic medication if clinically possible.

The most commonly used pharmacologic agents for treatment of neuroleptic-induced parkinsonism and acute dystonic reactions are:

<table>
<thead>
<tr>
<th>Pharmacologic Agent &amp; Type</th>
<th>Route</th>
<th>Dosing</th>
<th>Oral Daily Dosage Range (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>amantadine (dopaminergic)</td>
<td>oral</td>
<td>qd to BID</td>
<td>50 – 400</td>
</tr>
<tr>
<td>benztropine (anticholinergic)</td>
<td>oral, IM</td>
<td>qd to BID Q 30 min until symptom relief</td>
<td>1 – 8 oral 1 – 4 IM (*maximum single IM dose is 2 mg)</td>
</tr>
<tr>
<td>diphenhydramine (antihistaminic)</td>
<td>oral, IM</td>
<td>BID to QID</td>
<td>25 – 200 oral 10 – 200 IM (*maximum single IM dose is 100 mg)</td>
</tr>
<tr>
<td>trihexyphenidyl (anticholinergic)</td>
<td>oral</td>
<td>qd to BID</td>
<td>1 – 15</td>
</tr>
</tbody>
</table>

b. Neuroleptic-Induced Acute Dystonia--early-appearing (majority occur within 1-4 days of initiation or increase in dosage of psychotropic medication), sudden, brief or prolonged contraction of muscles, often the most dramatic, unusual postures generally involving spasms of head, neck, jaw and trunk muscles giving the appearance of the head being snapped back (torticollis), arched back, locked jaw (trismus), contorted face or eyes rolled up (oculogyric crisis). These may also include tongue protrusions laryngeal-pharyngeal dystonias, and dystonic postures of the limbs and the trunk. Incidence is about 2%, higher in men, in patients below age 30, and in patients on high dosages of high-potency neuroleptic medications. Acute dystonic reactions can be painful.

Treatment is as listed in above table.

c. Tardive Dystonia--late-appearing and consists of sustained, powerful, twisting, and predominantly extensor postures. It is often accompanied by other neuroleptic-induced movements. It is usually more disabling than other tardive dyskinetic movements.

Treatment: Treatment should be immediate most commonly with anticholinergic or antihistaminic drugs. If a response is not seen within two (2) hours after three (3) doses of these drugs have been administered, consider the etiology to be a non-neuroleptic induced dystonia.

d. Neuroleptic-Induced Acute Akathisia--akathisia literally meaning “inability to sit still” is characterized by the subjective feelings of restlessness and/or objective physical signs of restless movement. Clinical signs include continuous agitation with pacing, restless legs, inability to sleep, verbal complaints such as; “jitters,” “crawling out of my skin,” foot tapping,
rocking, and shifting weight. Usually early onset occurs within 5-60 days of medication initiation. Incidence is high, 21-40%.

Treatment: Reduce neuroleptic medication dosage, discontinue or change neuroleptic medication if clinically possible. Beta-adrenergic receptor antagonists, anticholinergics and benzodiazepines may be useful. Low-potency neuroleptic drugs may lend some advantages.

e. Neuroleptic-Induced Tardive Dyskinesia (TDs)--late-appearing movements commonly involving oral-buccal-lingual and facial muscles, fingers, toes, head, neck, trunk and hips as described in detail in this policy. In most serious cases, swallowing and breathing irregularities may occur. Risk factors for Tardive Dyskinesias include long-term neuroleptic use, increasing age (especially after age 65), female sex, presence of a mood disorder or a cognitive disorder. Patients with pre-existing brain disease are also especially at risk. Tardive Dyskinesias are generally painless, they are not provoked by urges to move, and unless severe, they do not interrupt activities of daily living. Tardive Dyskinesias can be crippling for a child who received only small doses of medication for a short period of time. The reality, tragedy and liability of tardive dyskinesia must be kept in mind every time psychotropic medications are prescribed.

(1) Movements typically seen with Tardive Dyskinesia include:

(a) Facial movements--tics or grimaces;
(b) Ocular movements--rapid or bursts of blinking;
(c) Oral movement--chewing, lip smacking, puckering and/or sucking of the lips or thrusting the lower lip;
(d) Lingual movement--tongue thrusts, tongue in cheek, tonic tongue, tongue tremor, and/or arthetoid, myokymic, or lateral tongue;
(e) Head/neck/trunk movements--retrocollis, torticollis, and/or shoulder/hip tortions;
(f) Upper limb movements--athetoid and/or myokymic finger, wrist, or arm movements or pill rolling;
(g) Lower limb movements--ankle flexion, foot tapping and/or toe movements.

(2) Description of movements:

(a) Athetoid movements--worm-like, writhing, vermicular rolling and twisting movements.
(b) Myokymic movements--twitching or jerking movements.
(c) Retrocollis--contractions of the neck muscles tilting or bending the head back.
(d) Torticollis--contractions of the neck muscles twisting the head to one side.
(e) Shoulder/hip tortions--twisting rolling movements of the shoulders and/or hips involving large sections of the body.
Individuals prescribed antipsychotic medication will receive printed educational materials on Tardive Dyskinesia at the time a consent for the medication is obtained, unless it is determined not to be in the person’s best interest by the psychiatrist/Advanced Registered Nurse Practitioner.

If persistent Tardive Dyskinesia is diagnosed, the psychiatrist/Advanced Registered Nurse Practitioner will:

- Document, in a progress note, the discussion of the diagnosis and risk versus benefit of medication continuation with the individual or legal representative;
- Add the new diagnosis of Tardive Dyskinesia to the Diagnostic & Statistical Manual (DSM) Axis III diagnosis in the medical record; and
- If continued use of antipsychotic medication is indicated, ensure informed consent is continued by having a new consent form signed.

Treatment: There is no drug of choice for treatment, but a variety of drugs may be helpful. These include dopaminergic agents, dopamine-depleting agents, gamma-amino-butyric acid (GABAergic) agents, vitamin E, calcium channel blockers, and adrenergic agents.

e. Neuroleptic Malignant Syndrome (NMS)--a life-threatening complication of neuroleptic medication use. It is caused by a massive dopamine imbalance resulting from use of dopamine-blocking agents. It can occur anytime and rapidly during the course of treatment. Symptoms include muscle rigidity and dystonia, akinesia, mutism, obtundation, altered consciousness, and agitation. Autonomic symptoms include high fever, sweating, increased blood pressure, and increased heart rate. This is a medical emergency that carries a 20% mortality rate if not recognized and treated appropriately.

Treatment: As soon as the condition is suspected, the resident shall be transferred to Unit 31 and referred to a neurologist as an emergency. In addition to supportive treatment, medications including dantrolene, bromocriptine, and amantadine are sometimes used. After recovery, such residents may only be re-challenged with antipsychotics with caution and by a trained psychiatrist/Advanced Registered Nurse Practitioner.

f. Medication-Induced Postural Tremor--rhythmical movements that are usually faster than one beat per second. Tremors typically decrease during sleep and periods of relaxation, and increase during periods of anger and increased tension. “Rabbit” Syndrome -- clinical signs include lip and/or perioral tremor, which may appear early or late in therapy.

Treatment: (1) use lowest possible psychotropic medication dosage; (2) minimize caffeine consumption; (3) bedtime administration of psychotropic medications to minimize daytime tremors; and (4) beta-adrenergic antagonists may be of benefit.

7. Toxic Serotonin Syndrome--A syndrome caused by a massive serotonin imbalance. It is a clinical condition related to the use of psychotherapeutic medications which may present as movement disorder. It is characterized by shivering, agitation, incoordination, restlessness, involuntary muscle contractions, hyperreflexia, diaphoresis and a hyperarousal state. It develops usually within a few weeks of prescribing a combination of a serotonin reuptake inhibitor with: monoamine (MAO) inhibitors, tricyclic & tetracyclic antidepressants, carbamazepine, and benzodiazepines. Toxic Serotonin Syndrome is a medical emergency which carries a 20% mortality rate if not recognized and treated appropriately.
Treatment: As soon as the condition is suspected, the serotonin reuptake inhibitor shall be discontinued and the resident transferred to Unit 31. After recovery, such residents may be re-challenged with serotonin reuptake inhibitors with caution and by a trained psychiatrist/Advanced Registered Nurse Practitioner.

8. Background: In particular, tardive dyskinesia (TD) is of great concern during psychotherapeutic medication therapy, since it is an adverse effect of treatment which can cause potentially severe physical, psychological and social disabilities. It should be detected as early as possible.

a. Complainants have won a significant number of lawsuits on this issue. Case law mandates the following:

   (1) there must be a balanced justification, (balance the benefits of prescribing psychotherapeutic medications against the risk of the occurrence, or the risk of worsening tardive dyskinesia or other tardive neurological conditions) for the use of psychotherapeutic medications;

   (2) psychotherapeutic medications must be prescribed appropriately;

   (3) cases must be monitored for the appearance of any adverse effects, including Tardive Dyskinesia;

   (4) the monitoring must be documented;

   (5) the Informed Consent must clearly spell out the potential adverse effects; and

   (6) any adverse effects, including tardive dyskinesia (TD), must be recognized, treated and managed in accordance with accepted clinical and national standards.

b. National standards encompass:

   (1) a focus on all adverse effects of psychotherapeutic medications, including all movement disorders, and, especially, tardive dyskinesia (TD);

   (2) adequate informed consent;

   (3) the use of a nationally recognized and standardized rating scale like the Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS) (for Florida State Hospital, use Abnormal Involuntary Movement Scale [AIMS] Examination & Rating, Form 77, Attachment 1).

   (4) raters must be adequately trained;

   (5) there must be a written policy that includes definitions, purpose, informed consent, assessment, methodology, formal rater training, frequency of assessment of abnormal movement disorder depending on the class of psychotherapeutic medication the resident is on, tracking of cases, documentation of treatment and management interventions, and involvement by Quality Assessment and Planning.
(6) Physician/Advanced Registered Nurse Practitioner progress notes that describe and justify the continued use of psychotherapeutic medication(s) in cases which have exhibited, or are exhibiting, adverse effects of psychotherapeutic medication administration.

9. **Guidelines:**

   a. The written policy for a collaborative process for medication side/adverse effect monitoring which will include:

      (1) education in side effects for residents at risk;

      (2) training in side effects for personnel who will routinely monitor for side/adverse effects;

      (3) personnel who will systematically monitor for Tardive Dyskinesia using a recognized, standardized monitoring tool for Tardive Dyskinesia such as the Dyskinesia Identification System: Condensed User Scale (DISCUS) or Abnormal Involuntary Movement Scale (AIMS) (for Florida State Hospital, use Abnormal Involuntary Movement Scale [AIMS] Examination & Rating, Form 77, Attachment 1).

      (4) competency based training with training updates for personnel responsible for completion of standardized ratings;

      (5) procedure for diagnosis and follow up of abnormal involuntary movement disorders resulting from neuroleptic use;

      (6) Tardive Dyskinesia incidence monitoring with analysis and trending of data by the facility Pharmacy and Therapeutics Committee; and

      (7) a quality assessment/improvement plan to track implementation of the guideline.

   b. It is the responsibility of all staff to monitor for potential side/adverse effects and report any symptoms to the psychiatrist/Advanced Registered Nurse Practitioner. The psychiatrist/Advanced Registered Nurse Practitioner is responsible for assessment of the reported symptoms and making any needed changes in medication therapy. The psychiatrist/Advanced Registered Nurse Practitioner or other physician will diagnose neuroleptic-induced abnormal movement disorders or adverse effects should they appear.

   c. Printed educational materials on abnormal involuntary movements will be made available to residents (unless it is determined not to be in the person’s best interest by the psychiatrist), family members and/or legal representative and staff.

   d. If a rating score suggests persistent Tardive Dyskinesia, another trained rater will conduct a reliability rating. A physician/Advanced Registered Nurse Practitioner will conduct a physical examination of the individual and if clinically indicated, will request a neurological consultation for confirmation of the diagnosis.

10. **Documentation:**

    a. Presence or absence of side/adverse effects will be documented by the psychiatrist/Advanced Registered Nurse Practitioner and registered nurse in their respective monthly progress notes.
b. At a minimum, a baseline formal rating will be documented, using a standardized assessment tool, on admission; then quarterly for those receiving the first generation antipsychotic medication and/or diagnosed with Tardive Dyskinesia; semiannually for persons receiving atypical antipsychotic medications including clozapine.

c. If Tardive Dyskinesia is diagnosed, the psychiatrist/Advanced Registered Nurse Practitioner will:

   (1) document, in a progress note, the discussion with the resident or legally appointed guardian/guardian advocate as appropriate, the diagnosis and risk versus benefit of medication continuation; and

   (2) add the new diagnosis of Neuroleptic-Induced Tardive Dyskinesia to Axis I (and Tardive Dyskinesia to Axis III) diagnosis (Form 207, Current Diagnosis) in the medical record;

   (3) complete and send a referral to the Movement Disorder Clinic or Neurology Clinic if the Abnormal Involuntary Movement Scale rating is two (2) or more in two (2) or more of the seven (7) body areas examined or three (3) or higher in one of the seven (7) body areas examined (see Abnormal Involuntary Movement Scale [AIMS] Examination & Rating, Form 77, Attachment 1).

   (4) document in the medical record any recommendation/s for management and follow-up after the resident is seen at the Movement Disorder Clinic or Neurology Clinic;

   (5) document in the medical record any variance in the finding/rating between the Movement Disorder Clinic/Neurology Clinic and the psychiatrist/Advanced Registered Nurse Practitioner.

d. Monthly Progress Note--The psychiatrist/Advanced Registered Nurse Practitioner shall perform an informal neurological assessment on every resident monthly and shall document the result in the monthly progress note. Whenever an Abnormal Involuntary Movement Scale is administered the score shall be entered into the monthly progress note and a pertinent comment shall be made concerning management. Compliance with this section shall be required.

e. Computer Input Requirements—Once the Abnormal Involuntary Movement Scale has been completed by the attending physician/Advanced Registered Nurse Practitioner and/or the physician assigned to the Movement Disorder Clinic/Neurology Clinic, designated unit staff will enter the scores and related information in the computer. Each unit will be responsible for developing its own procedure for ensuring that all Abnormal Involuntary Movement Scale reports are entered into the computer in a timely manner.

f. Notification—It will be the Recovery Team’s responsibility, in the event that a diagnosis of a probable neuroleptic-induced movement disorder has been made by the psychiatrist/Advanced Registered Nurse Practitioner, Movement Disorder Clinic or the Neurology Clinic, to inform the resident, guardian, guardian advocate or relevant family member(s) as appropriate, of the finding(s). All transactions must be fully documented in the medical records.

g. Clinical Staff Training—At a minimum, Staff Development shall conduct training for all clinical staff at orientation on the causes, recognition, and management of drug-induced movement disorders. Attendance of each person shall be certified by a completed Staff
Training and Information Reporting System (S.T.A.I.R.S.) form. Physicians and Advanced Registered Nurse Practitioners shall receive a formal training on the Abnormal Involuntary Movement Scale by the Hospital Clinical Director/designee.

h. Quality Assurance--This department shall gather information on the prevalence and incidence of drug-induced and other movement disorders on a regular basis from each residential unit, and will assemble hospital-wide statistical information on this topic.

i. Movement Disorder Clinic--A clinic held in Unit 31. The clinic's function may be transferred to other locations when required. To this clinic should be referred:

   (1) any resident with Abnormal Involuntary Movement Scale score of two (2) or more in two or more of the seven (7) body areas examined; or Abnormal Involuntary Movement Scale score of three (3) or more in one (1) body area examined (see Abnormal Involuntary Movement Scale [AIMS] Examination & Rating, Form 77, Attachment 1);

   (2) any resident in whom there is doubt or difficulty in determining whether or not a movement disorder exists, at any time.

j. Neurology Clinic--A specialty clinic held in Unit 31. To this clinic shall be referred any resident in whom the Movement Disorder Clinic is experiencing doubt or difficulty in diagnosing, assessing, treating or managing a movement disorder or possible movement disorder. This clinic may take the place of the Movement Disorder Clinic.

k. Printed Educational Material--The Staff Development department will gather and design appropriate material to educate all clinical staff. This material may also be shared with guardians, families, and friends of the residents.

l. Special Resident Populations--Psychotherapeutic medication treatment for special resident populations such as children under 12, the elderly, mentally retarded residents, the debilitated, and persons known to have a history of medication sensitivity must be approached with caution and, when indicated, should be in conjunction with consultations from persons knowledgeable about medication use with these special populations.

(Signed original on file in Central Health Information Services)

DIANE R. JAMES
Hospital Administrator

Attachments:
1. Abnormal Involuntary Movement Scale (AIMS) Examination & Rating (Form 77)
2. Flow Process for Assessing Abnormal Movements dated 2/05/07

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure has been revised to spell out acronyms/abbreviations; use the word “psychotherapeutic” medication and correct language structure for better flow.
### FACIAL & ORAL MOVEMENTS
- **Muscles of Facial Expression**
  e.g., movements of forehead, eyebrows, periorbital area, cheeks, frowning, blinking, smiling, grimacing
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Lips and Perioral Area**
  e.g., puckering, pouting, smacking
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Jaw**
  e.g., biting, clenching, chewing, mouth opening, lateral movement
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Tongue**
  Rate only increases in movement both in and out of mouth, darting in and out of mouth. DO NOT rate inability to sustain movement.
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

### EXTREMITY MOVEMENTS
- **Upper (arms, wrists, hands, fingers)**
  Include choreic movements (i.e., irregular, rapid, spontaneous, purposeless), athetoid movements (i.e., slow, irregular, complex serpentine). DO NOT include tremor (i.e., regular, repetitive, rhythmic)
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Lower (legs, knees, ankles, toes)**
  e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

### TRUNK MOVEMENTS
- **Neck, shoulders, hips**
  e.g., rocking, squirming, twisting, pelvic gyrations
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

### GLOBAL JUDGEMENT
- **Severity of abnormal movements overall**
  (Based on the highest single score on above items)
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Incapacitation due to abnormal movements**
  - Code: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

- **Patient’s awareness of their own abnormal movements**
  Rate ONLY resident’s report, not observations.
  - No awareness = 0
  - Aware, no distress = 1
  - Aware, mild distress = 2
  - Aware, moderate distress = 3
  - Aware, severe distress = 4

### DENTAL STATUS
- Current problems with teeth and/or dentures
  - Yes, No

- Are dentures usually worn?
  - Yes, No

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**INSTRUCTIONS:**
To be completed by a trained Physician/Advanced Registered Nurse Practitioner (ARNP). Please complete the examination procedure BEFORE making the ratings. To be completed per Florida State Hospital Operating Procedure 155-24.

To be filed in the resident’s chart under “Psychotropic Medications” section.
GENERAL INSTRUCTIONS:
1. While resident is performing each step, observe all body areas.
2. For residents who are not/partially cooperative, examination & rating are based upon the physician’s best clinical judgment of movements observed.
3. Use a chair without arm rests.
4. Please document any further comments in resident’s progress notes.

STEP ONE:
Ask patient whether there is anything in their mouth such as candy or gum. If there is, it must be removed.

STEP TWO:
Ask the patient about the current condition of their teeth. Does the patient wear dentures? Do teeth or dentures bother them?

STEP THREE:
Ask the patient whether they have noticed any movements in the mouth, face, hands or feet.

STEP FOUR:
Have the patient sit in a chair with hands on knees, legs slightly apart and feet flat on floor.

STEP FIVE:
Ask the patient to sit with hands hanging unsupported.

STEP SIX:
Ask the patient to open their mouth. (Observe tongue at rest inside mouth.) This procedure is done twice.

STEP SEVEN:
Ask the patient to stick out their tongue. (Observe for tongue movements.) This procedure is done twice.

STEP EIGHT*:
Ask the patient to tap their right thumb with each finger as rapidly as possible. Repeat procedure using left hand.

STEP NINE:
The examiner must flex and extend each of the patient’s arms. Note any rigidity.

STEP TEN:
Ask the patient to stand up with their arms at their sides.

STEP ELEVEN:
Ask the patient to extend both arms out in front with palms down.

STEP TWELVE*:
Ask the patient to walk a few paces, turn and walk back. (Observe gait.) Do this procedure twice.

* activated movements
Process for Assessing Abnormal Movements

**STEP**

<table>
<thead>
<tr>
<th>WHO</th>
<th>RESIDENT</th>
<th>PSYCHIATRIST/ARNP</th>
<th>HISS*</th>
<th>IS*</th>
<th>MOVEMENT DISORDER CLINIC/NEUROLOGY CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEED</td>
<td>Assess For Tardive Dyskinesia Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REVIEW</td>
<td>Review Resident's Psychotherapeutic Medication Regimen (Type And Dosage) Categorize To Determine If Receiving 1st Or 2nd Generation Antipsychotic Medications</td>
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<tr>
<td>ASSESS</td>
<td>Perform AIMS* (Every 3 Months For 1st Generation Antipsychotic Medications And Every 6 Months For 2nd Generation Antipsychotic Medications) Including Clozapine Complete And Review Severity Ratings</td>
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<tr>
<td>DETERMINE</td>
<td>AIMS* Score Less Than 2 in Any Body Area.</td>
<td>NO</td>
<td></td>
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<td></td>
<td></td>
<td>YES</td>
<td></td>
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<tr>
<td>COMPLETE / REFER</td>
<td>Psychiatrist/ARNP Completes &amp; Sends Referral For Review To The Neurologist Or Movement Disorder Clinic</td>
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<tr>
<td></td>
<td>Neurologist/Clinic Assesses Movement Disorder Symptoms Makes Recommendations Determines Follow-Up Schedule Notifying</td>
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<tr>
<td>ASSESS</td>
<td>Psychiatrist/ARNP Sends Completed Form To HISS* For Data Entry (Includes Ratings And Date For Next Scheduled AIMS*)</td>
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<tr>
<td>SCHEDULE/REPORT</td>
<td>IS Generates Report Providing List Of Scheduled AIMS* Assessments &amp; Follow-Up Appointments At The Movement Disorder Clinic/Neurology Clinic IS Sends Report To Prescribers, HISS*, Unit Nurse Managers And MSDs*</td>
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<tr>
<td>NEED MET</td>
<td>Assessment Completed</td>
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</tr>
</tbody>
</table>

*HISS — Health Information Specialist Supervisor IS — Information Systems AIMS — Abnormal Involuntary Movement Scale MSDs — Medical Service Directors

Attachment 2
Operating Procedure 155-24