District of Columbia
Developmental Disabilities Administration

Health and Wellness Standards

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Standards: Standards are requirements for people who receive supports from DDA. Standards will be listed in this column and numbered accordingly, with a detailed explanation of the standard in the right-hand column. ***Applies to:*** The people whom the standard affects will be noted in this column.	**Introduction** The Developmental Disabilities Administration (DDA) is responsible for the oversight and coordination of all services and supports provided to eligible people with intellectual and developmental disabilities in the District of Columbia. One of the key purposes of the *Health and Wellness Standards ("Standards")* document is to provide the information and tools necessary to advocate for the best possible health care and health outcomes for people with intellectual and developmental disabilities, thus ensuring a good quality of life. The *Standards* do not focus on specific health conditions, but rather provide a guide for the assessment, planning, delivery, and documentation of essential health supports. People with disabilities and those who support them must continually seek and be provided with health education and advocacy. Each designated agency, specialized service agency, and person or family member who manages the person's supports is responsible for ensuring that health services are provided and documented appropriately. This responsibility applies regardless of whether the person is supported through the Home and Community Based Services Waiver for People with Intellectual and Developmental Disabilities (HCBS IID waiver) or, the person lives in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID). The applicability of these guidelines for people living independently or with family members will vary. DDA's expectations for health and wellness services emphasize the importance of: • Preventative health; • Continual assessment for changes in health; and • Care coordination. Tools for accomplishing these goals include: • Nursing Assessment; • Health care management planning; • Health Passports to communicate health issues; and • Annual Preventive Health Screening Report to guide the scheduling of preventative screening and assessments.	***Documentation:*** The documentation of health and wellness supports is an essential part of the provision of quality care. The location of health and wellness related documentation will be noted in this column.

Variances: Variances to the *Health and Wellness Standards* must be documented by an involved medical or nursing professional. ***Applies to:*** All people receiving DDA funded Services.	Health and wellness services, and the roles of various health professionals and support personnel must be specifically noted within the person's Individual Support Plan (ISP). **Variances** Circumstances may occur for which application of a standard may not be indicated or may not be in the person's best interest. When this occurs, there should be discussion(s) between the person, the health care provider, support team members, and/or the person's health care decision-maker (if there is one). A variance is only proper where (1) it is approved by a medical professional; and/ or (2) the person or his or her substitute decision maker provides informed consent. Variances for the convenience of the support team or health care provider are unacceptable. A person's right to refuse treatment must be respected. However, the person's provider is responsible to ensure that the person's decision is based on informed choice. Examples of situations where a variance might be indicated include: • A healthy person may need less frequent physical exams than on an annual basis; • Contractures or other physical difficulties may prevent certain testing; or • Certain preventative tests may not be desired in the presence of a terminal illness or advanced age. If a variance occurs secondary to difficulties such as fear of blood drawing, Pap test, etc., then there must be information in the person's health file that indicates attempts have been made or considered and determined to be not clinically indicated to desensitize the person. The person should also have an appointment support plan.	***Documentation:*** Any variance in health and wellness services needs to be documented in the health record. This documentation must include the following: rationale for the variance; any related discussions between the person, health care provider, support team members, and health care decision-maker; and any actions or plans to be taken to address the variance.

Standard 1 ***Health Passport:*** A current emergency factsheet, following the standardized *Health Passport* format, will be accessible and available in all files (including home, agency, day program, etc.), and to all those involved in supporting the person. ***Applies to:*** ***Required for:*** People residing in an ICF/IID. People enrolled in the HCBS IID waiver who receive residential habilitation, supported living, or host home supports. Quarterly updates are required in ICF settings and annually in waiver settings. Any changes in health care delivery (i.e. medications, diagnosis, diet, etc.) shall require updating the Health Passport more frequently as changes occur. ***Recommended for:*** The Health Passport is recommended for people living independently or in a family home.	**Health Passport** Access to accurate and timely medical history information and current treatment modalities is essential for safe and effective emergency care, and for the sharing of information to optimize consultation with medical specialists. A *Health Passport* serves this purpose, whether available on paper or in an electronic form. The required information to be included in the *Health Passport* includes: 1. **Demographic Information** • Person's name • Address • Phone number • Date of birth • Medicaid/Medicare numbers • "Do Not Resuscitate/Do Not Intubate" status (Attach the physician's order and other End of Life planning documents, such as an Advanced Directive, to the *Health Passport)* • Agency number, and • Personal information (height, weight, race, gender, hair, and eye color). 2. **Contact Information for** : • Healthcare decision-maker, next of kin, or legal guardian (Attach the court order or other documentation to the *Health Passport)* • Provider agency, and designated staff (QDDP, Registered Nurse) • DDA Service coordinator • Healthcare providers (Primary care physician, dentist, psychiatrist, psychologist, medical specialists (e.g. cardiologist, neurologist, gynecologist, etc.) 3. **Functional Information** • Cognitive skill level • Adaptive skill level and adaptive equipment (i.e. communication board, walker, cane, or specialized eating utensils) • Communication level and methods (This section must impart to hospital staff the person's communication	***Documentation:*** A copy of the current *Health Passport* will be maintained at a person's residence. It is recommended that a current portable copy of the *Health Passport* accompany a person to day and/or vocational services, and to all medical appointments.

The Health Passport document will be introduced to the person and family member by the Service Coordinator.	style(s). For example, does the person use echolalia, tend to answer "yes" to most or all questions, or is the person able to answer many questions about his/her symptoms and history?) • Diet, food intolerance, texture information • Ambulation status (i.e. walks, needs assistance, non-ambulatory) 4. **Consent Procedures Information** • Capacity to make medical decisions • If applicable, contact information for substitute health care decision-maker 5. **Medical Information** • Allergies (Drug, food, environmental; include emergency treatment, if indicated) • Special Precautions (Such as a visual or hearing impairment or special turning and positioning schedules.) • All current medical diagnoses and resolved medical diagnoses. This includes diagnoses that may be temporary, such as a urinary tract infection, MRSA infections, etc. so that a health care provider seeing someone for the first time has an accurate reference of current and past health conditions. • Medical Problem list (specific up-to-date information about all past medical problems, surgeries, special treatments including dates and current status) 6. **Vaccine Information** • Include type, dates, source, and vaccine lot 7. **Medication Information** • Medication names, start dates, dosages, times, routes, reason for medication and discontinuation dates All of this information is important, particularly when a person is hospitalized and staff needs to become familiar with the person's communication style(s) and ambulation status pre-hospitalization. All support staff must be oriented to the importance of the *Health Passport*, and be familiar with the need to ensure that the *Passport* accompanies the person to all medical or dental appointments and emergency room visits.	

	In the emergency room, and if the person is admitted to the hospital, staff must advocate that the *Health Passport* follows the person in transit from the ER to the unit and that the receiving hospital staff is knowledgeable about its contents. For people living independently or in family homes, the *Health Passport* is optional. However, it is the service coordinator's responsibility to educate the person and/or his/her healthcare decision-maker about the benefits of the *Health Passport* and to provide assistance in its development and maintenance of current information. For people receiving day/vocational services, the current *Health Passport* will be developed and maintained by the residential services provider and sent to the day/vocational provider. Coordination will be needed between the residential staff and the day/vocational services provider to ensure that the *Health Passport* is current and includes the most up-to-date information. Technical assistance can be obtained from the DDA Health Initiative DDA Health and Wellness registered nurses. **Source***:* The *Health Passport (Appendix 1)* document is available at http://dds.dc.gov	

Standard 2 ***Coordination of Health Care Services:*** Health care delivery typically requires services from multiple providers working across a variety of systems. Care coordination is needed to ensure that services meet people's complex needs and that residential support teams and service coordinators are knowledgeable of services received from all systems. ***Applies to:*** All people receiving services through DDA.	**Coordination of Health Care Services** Coordination of health care services is the responsibility of the residential service provider. This responsibility will be directed by a registered nurse (RN) even if certain aspects of this responsibility are delegated to other staff. When delegating, the RN needs to be sure that the staff has the capacity to perform the necessary tasks, including oral and written communications and ability to interact with community agencies (See Board of Nursing Delegation Tree in the Appendix.). Each service agency and each registered nurse needs to have a process in place to ensure that all standing recommendations are periodically reviewed to ensure that they are adequate and eliminate unnecessary, although perhaps historic, recommendations. Each service agency should have a procedure in place across all service settings to maintain current *Health Passports*, paying special attention to the accuracy of: • Clarity of who is the health care decision maker • Current contact numbers (for a 24 hour period) of substitute decision makers • Current contact information for PCP and specialists, including psychiatrist • Current medications • Updated list of medical problems • It is suggested that whatever staff person is responsible for taking medical orders for pharmacy purposes should modify the *Health Passport* at the time the order is started. For new health problems, diagnoses should be confirmed with the PCP. For people who do not receive nursing services, the service coordinator should work with the person and their support team to maintain a *Health Passport*. This can be taught to the family member responsible for care or health care decision-making. However, people and families reserve the right to decline this service. The transition from hospitalization back to the home can be a time period where the person is at high risk for adverse outcomes. Good communication among the support team	***Documentation:*** Documentation that provides evidence of coordination of care will be included in the Health Record. This coordination of services should be reflected in the nursing, therapeutic service, primary care, and specialty care progress notes.

	and implementing consistent processes can reduce such risks. *The Transition of Care Guide* was developed to assist community support providers, service coordinators and healthcare decision makers in obtaining the information needed to promote safe healthcare transitions from the hospital or long term care facility to the home. **Source***:* The *Transition of Care Guide (Appendix 10)* document is available at http://dds.dc.gov.	

Standard 3	**Preventative Health Care**	
Preventative Health Care: Preventative health care focuses on optimizing a person's potential for health, function, and overall wellbeing. Unless a variance can be documented, health practitioners must adhere to the USPSTF Guidelines. ***Applies to:*** ***Required for:*** People residing in ICFs/IID. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services. ***Recommended for:*** Preventative health care is recommended for people living independently or in a family home.	DDA's requirements for preventative health screening by age and gender are found on the Annual Preventive Health Screening Report. The Annual Preventive Health Screening Report offers male and female versions which list the recommended screenings from the U.S. Preventative Screening Task Force (USPSTF) Guidelines. All preventative screenings should be recorded on the Annual Preventive Health Screening Report. (See Appendix.) If a person requires a variance from the USPSTF recommended screenings, its rationale must be documented in the record by a PCP. *Health Form 2* (Direct Observation) and *Health Form 3* (Diagnostic Review) are supplemental forms used to ensure that people receive quality care. *Health Form 2* (Direct Observation) is generally completed by the direct support professionals to assist in the recording of health-related information, and for communicating recent health changes to a supervisor or healthcare provider. (See Appendix) *Health Form 3* (Diagnostic Review) offers an instrument to organize a systematic review of a person's current assessments, physical exam, specialists' reports, and medical intervention in a systemic way. (See Appendix) While the use of the Annual Preventive Health Screening Report is required, the use of *Health Forms 2 and 3* is optional, but highly recommended. *Annual Preventive Health Screening Report (male & female), Health Form 2, and 3* are available at: http://dds.dc.gov The Glasgow Depression Scale Questionnaire is designed to screen for depression in people with an intellectual disability by assessing behavioral symptoms of clinical depression. There are two versions of the questionnaire (self-reporting and care-giver supplemental). The self-report version is for people who can report on their own symptoms, whereas the care-giver supplement version is used for people who are nonverbal and can't self-report and the registered nurse would need to complete.	***Documentation:*** Annual Preventive Health Screening Report, which is the required form for documentation of preventative health screenings, is to be maintained in the Health Record.

	The Glasgow Depression Scale Questionnaire shall be completed at least annually along with the nursing assessment and/or more frequently if a change in mood is observed. A score of 13 or greater will require the registered nurse to seek a referral for mental health consultation or from a psychologist (if the person resides in an ICF-IDD setting). Glasgow Depression Scale Questionnaire (see Appendix 20)	

Standard 4	**People Experiencing Declining Health**	
Support during Declining Health: All people will receive support from healthcare providers, residential support staff, and DDA service coordinators to ensure that changes in health care needs are adequately addressed. ***Required for:*** All people receiving services from DDA.	Staff who support a person on a regular basis are responsible for knowing the typical patterns of that person's life in order to detect any changes that need to be referred to the PCP. Depending on the level of supports received and by whom, the residential staff, nursing personnel, or service coordinator will be responsible for ensuring that all changes are thoroughly documented to assist the PCP and/or medical specialists in the diagnosis, treatment and evaluation of the health situation. The service coordinator working in collaboration with the person, health care decision-makers, guardian (if named), and residential agency staff will ensure that: • The PCP conducts a timely and adequate medical evaluation to identify the etiology of the problem(s); • The PCP makes timely referrals to medical consultants and specialists to diagnose and treat the condition(s); and • Any recommendations resulting from such visits are acted upon in a timely manner consistent with the person's interests and health care needs. The findings from the PCP and medical specialists must be integrated into a comprehensive plan of care that is reviewed by the support team that includes the person and his/her healthcare decision-maker (if one is needed). The comprehensive plan of care must include information on the person's current status, any actions to be taken/not taken, rationale for these actions, an explanation of risks and benefits, and issues that may constitute a change in the direction of care. If a recommendation by a specialist is to be deferred due to the person's best interest or a decision by the person or his/her healthcare decision maker to decline treatment, that information must be thoroughly documented in a consultation report or progress note. Any change in function may require the support team to reconvene an ISP meeting to plan for additional supports or changes in the person's current routine, e.g., a temporary respite from a job or day program. Consideration must also	***Documentation*** For people experiencing a decline in health, a comprehensive plan of care must be documented by the PCP, the DDA Service Coordinator and/or residential support registered nurse in the health record progress notes. Deferral or decline of any health recommendation made by the PCP or specialists must be thoroughly documented in the health record progress notes.

	be made as to whether the illness necessitates additional support in healthcare decision making. For example, the person may need temporary support to make decisions or even the appointment of a temporary guardian. (See Section 6 on Medical Consent.) The entire support team should evaluate what supports the person needs to maintain a good quality of life consistent with the person's personal preferences, including but not limited to pain management, nutritional intake, recreation, spiritual support, and access to friends and family. DDA offers technical assistance to people and their support teams to assist them during periods of functional decline through the Health and Wellness staff. Indications for consulting these resources include: • Frequent use of emergency room or hospitalizations • Newly diagnosed, serious health conditions • Major chronic conditions with a likelihood of poor outcomes • Lack of consensus regarding diagnosis or treatment • Sudden, unexplained behavior changes • Rapid decline in functional skills possibly related to poor health. Any such changes to service type, frequency, or duration in waiver services requires a team meeting along with amendments to the ISP and the HCBS waiver plan of care.	

Standard 5 ***Health Care Management Plan (HCMP):*** Anyone receiving nursing services via the HCBS Waiver or who lives in an ICF/IID should have a HCMP developed. ***Required for:*** Anyone enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services, or anyone who lives in an ICF/IID. Quarterly updates are required in ICF settings and annually in waiver settings. Any changes in health care delivery (i.e. medications, diagnosis, diet, etc.) shall require updating the HCMP as changes occur.	**Health Care Management Plan** The Health Care Management Plan (HCMP) is a comprehensive and individualized document used to summarize a person's health needs and outlines interventions required to maintain optimal health. The HCMP will address health concerns that impact people beyond the residential setting, to include the day/vocational supports. The HCMP is developed or amended during the annual Individual Service Plan (ISP) process and is attached as an addendum to the ISP. The HCMP is used to guide the implementation of all healthcare activities across multiple settings and must be incorporated within the ISP. For example, for a person newly diagnosed with diabetes, the information needed to safely address and manage the person health concerns in both the residential and day/vocational settings must be incorporated into the HCMP. The HCMP is based on data gathered from the following sources: • Annual Preventive Health Screening Report- a record of preventative health screenings • Health Form 2 (use of form is optional) – a record of observations by direct care staff • Health Form 3 (use of form is optional) – chart review of medical diagnoses • Nursing Assessment – The RN must choose between one of two formats to use or may use the Therap electronic nursing assessment form (see below), or another electronic nursing assessment form as approved by DDS. • Person Centered Thinking skills and tools A new HCMP shall be developed annually by the registered nurse and presented at the person's ISP meeting by the nurse or his/her designee. If the HCMP is computer-based, with each annual ISP, a date and electronic signature must be affixed to the document. The date shall correspond with the ISP date and be recorded on the HCMP face page under "Date of Development." Subsequent reviews shall be documented on the last page of the HCMP (see last page of template document). The HCMP must be reviewed minimally on a quarterly basis, by a	***Documentation:*** A current HCMP will be maintained in the health record. The HCMP will be updated at least annually as part of the ISP process, and more frequently in the instance of people with changing health issues.

	registered nurse, in ICF/IID settings. "No Adjustments/changes" shall be written if there are no adjustments/changes at the time of the quarterly review. The HCMP must be updated more frequently if the person receives a new diagnosis, exhibits a change in health status, or a nursing assessment establishes the need for additions or modifications to the existing HCMP. These updates must be done within 7 days of identifying of the new health concern. With urgent health concerns, the HCMP should be updated immediately. For new admissions to the agency, the HCMP must be initiated by the registered nurse within 30 days of admission. The registered nurse's signature and the date of any updates including the quarterly reviews must be documented on the last page of the HCMP. A signature represents that the registered nurse has reviewed the updated HCMP. If an electronic record system is in place, agency procedures shall guide the determination of what constitutes an electronic signature. *For information and guidance on developing* HCMP - *refer to the "Developing Health Care Management Plan" document in the Appendix.* **Role of the Qualified Developmental Disabilities Professional** The Qualified Developmental Disabilities Professional (QDDP) qualifications are subject to state interpretations required under federal Intermediate Care Facilities for People with Developmental Disabilities as members of the interdisciplinary team. QDDPs and the function performed by personnel within that role are integral to the coordination of services and supports across the broad community experiences for people with intellectual and other developmental disabilities. This standard describes the expectation of the QDDP as an integral part of a health services team and support professional working collaboratively with nurses and other health personnel. The delivery of person-centered services	

	and supports are dependent on a well-coordinated team that is able to assess the person's priorities, and ensure that all of the goals of the individualized support plan are met in a manner that (1) respects what is important to and for the person, (2) utilizes available community-based, integrated resources, and (3) meets expectations for high quality services. In settings where registered nurses are part of the support team, the QDDP and the registered nurse must work collaboratively. While the registered nurse is responsible for the development of the Health Care Management Plan (HCMP) [see Standard 5, page 15], the QDDP must be knowledgeable of all aspects of the plan. The skills of the QDDP are essential in attaining the desired outcomes articulated within the HCMP. They do this through: ▪ Ensuring that all Direct Support Professionals (DSPs) have received the training they need to fulfill their responsibilities as outlined in the intervention section of the HCMP ▪ Monitoring the acquisition and maintenance of all adaptive equipment, and ensuring that DSPs are competent in the use of the equipment ▪ Ensuring that all appointments with primary, specialty and auxiliary health care providers are kept, including adequate transportation and staff support during the appointment. ▪ Monitoring the impact of a person's health condition(s) on their ability to engage in employment and other community activities. In addition, the QDDP must ensure consistency among external and internal programs and disciplines. For example, all professional reports (primary care, specialists, and therapists) must be reviewed to determine what follow up is needed, and to monitor for any inconsistencies. For example, a speech pathologist may develop a mealtime protocol with positioning requirements that contradict the recommendations of the physical therapist. The QDDP must contact both therapists to ensure that the discrepancies are	

	resolved. This work must be closely coordinated with the registered nurse, following agency procedures for communication and meeting schedules. It is recommended that when the QDDP documents the execution of their responsibilities, they adhere to the following guidelines: ▪ Use the desired outcomes of the HCMP as a guide to completely address all of the identified health needs for the person. QDDPs are required to review the HCMP quarterly in both ICF and Waiver settings and place a note in MCIS. ▪ Avoid charting identical information as the registered nurse. Instead, document the specific functions of the QDDP i.e. training for DSPs on health matters, acquisition and maintenance of adaptive equipment, medical appointments, impact of health conditions on the person's ability to engage in employment and other community activities. **Nursing Assessment** The nursing assessment is a key component of nursing practice, required for planning and provision of person-centered care. The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with the person, family and the multidisciplinary health care team to achieve goals and health outcomes. The version of the redesigned nursing assessment tool is ideal to be utilized in both the ICF and Waiver settings. The nursing assessment tool is described below to support the development of the HCMP. Alternatively, providers who are using Therap may use the electronic nursing assessment form in Therap. If an agency is using another electronic health record that includes a nursing assessment format, DDA must review the format to ensure that all relevant data is being collected. Once DDA has approved the electronic format, that format can be substituted for Nursing Assessment. Send a request for review of the format to Shirley Quarles-Owens, RN, MSN, Supervisory Community Health Nurse, at (202) 730-1708 or shirley.quarles-owens@dc.gov.	

	The Nursing Assessment Tool is to be utilized by a Registered Nurse (RN) in assessing adults with significant intellectual and/ or physical disabilities. This assessment is designed to review body systems for people who can communicate as well as for people who are unable to communicate their health care needs. The Nursing Assessment Tool includes a full physical assessment along with the collection of other health-related data from staff and/or family members. (*See* Nursing Health and Safety Assessment Interpretive Guidelines in the Appendix.) A nursing assessment should be completed as part of the initial Individual Support Plan and revised annually. Changes in health condition during the 12 month period can be noted in a progress note. If there is a **significant** change in health condition any time during that 12 month period (for example, the person experiences a stroke or another catastrophic health incident, the nursing assessment must be revised). The nursing assessment process described in this document is part of a comprehensive assessment leading to the identification of health problems and expected outcomes, the creation of a HCMP and the implementation and evaluation of a plan of care through an interdisciplinary process. The HCMP is the logical conclusion of the nursing assessment and is an integral part of it. No assessment will be considered complete unless the HCMP is developed or revised. **Expected Outcomes** The HCMP includes the identification of "Expected Outcomes." It is important to identify expected outcomes in collaboration with the person to the fullest extent possible in keeping with their preferences and goals identified through the person centered thinking process. Health care that is focused on outcomes: ▪ Person-Centered HCMP ▪ Promotes the participation of the person in their own health care ▪ Clearly communicates the expectations for the plan of care	

	▪ Promotes accountability Expected outcomes: ▪ Focus on the person and are a part of person-centered thinking ▪ Consist of clear and concise statements ▪ Are measureable ▪ Are time-limited ▪ Present realistic goals ▪ Represent a mutual decision between the nurse, the person and any health care decision-maker **Expectations for Direct Support Professionals in Supporting the Health of People with Intellectual Disabilities** The HCMP delineates the interventions that are the responsibility of the DSP. The DSP needs to be able to demonstrate competency to complete all interventions as outlined, but would be expected to reference the HCMP when discussing the health support needs of a particular person as part of a support team meeting or monitoring session, with the exception of the critical parameters outlined below. The National Association of Direct Support Professionals (DSP) Code of Ethics (https://www.nadsp.org/library/code-of-ethics/10-library/72-code-of-ethics-full-text.html) notes that one of the responsibilities for a DSP is to support "…the emotional, physical, and personal well-being of the individuals receiving support." The code goes on to define how this is implemented to include vigilance "in identifying, discussing with others, and reporting any situation in which the individuals I support are at risk of abuse, neglect, exploitation or harm." INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program to improve the identification, evaluation, and communication about changes in a vulnerable person's status. It was first designed in a project supported by the Centers for Medicare and Medicaid Services and evaluated in 30 nursing homes in New York and Massachusetts. Due to the effectiveness of the program, today it is used in many nursing homes across the country. One of the tools developed by INTERACT is a communication tool that uses the mnemonic *Stop and Watch* to train staff on important observations to make and report.	

	DSPs are trained to report changes they note immediately to their supervisor who follows the protocol identified by their agency for reporting health changes. Depending on the setting and the independence of the person, the person themselves may call their primary care provider, or an agency RN is notified who then triages the information for relay to the PCP or the activation of emergency medical services. DSPs need to be knowledgeable about: (1) signs and symptoms to report to a supervisor that may indicate a change in health status (2) specific diet, behavioral and positioning protocols and (3) their responsibilities as outlined in each person's health care management plan (HCMP). <u>Signs and Symptoms</u> DSPs need to be trained on the elements of *Stop and Watch* and reporting protocols for the individual and their agency. The essential observations include: ✓ **S**eems different than usual ✓ **T**alks or communicates less ✓ **O**verall needs more help ✓ **P**ain, new or worsening. Participates less in activities. ✓ **a**te less ✓ **n**o bowel movement in three days – or diarrhea ✓ **d**rank less ✓ **W**eight change ✓ **A**gitated or nervous more than usual ✓ **T**ired, weak, confused or drowsy ✓ **C**hange in skin color or condition ✓ **H**elp with walking, transferring or toileting more than usual Agency policies need to outline DSP training and reporting protocols. <u>Protocols</u> In addition to knowing these critical reporting parameters, DSPs are expected to know the following specific information about the people they support: 1. Diet restrictions related to diabetic, low sodium, fluid restricted or calorie restricted diets.	

	2. Recognition of high or low glucose and emergency procedures for people with insulin-dependent diabetes. 3. Food, environmental, seasonal or drug allergies. 4. Seizure recognition and first aid. 5. Existence of mealtime, positioning and behavioral support plans and protocols. 6. Use of adaptive equipment including internal devices such as pacemakers, baclofen pumps and shunts. 7. When to activate the Emergency Response System (911) and when to initiate CPR and the Heimlich maneuver.	

Standard 6 ***Medical Consent:*** Consent from the person or his/her healthcare decision maker (if there is one) is required prior to medical treatment, proposed changes in medical treatment, or proposed changes/additions to medication regimens. The person or his/her medical decision maker is also informed of any changes in health status. ***Applies to:*** People who live in an ICF/IDD. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, or host home services.	**Medical Consent** The law presumes that everyone, including people with intellectual and developmental disabilities, has capacity. However, some people have been assessed by a clinician and determined not to have the capacity to consent for medical treatment. Capacity is the ability to understand the nature and consequences of one's acts. The person must be able to understand his or her situation, understand the risks, and communicate a decision based on that understanding. People who are unable to give consent, with or without support, may have a: • substitute healthcare decision maker • permanent limited guardian for healthcare decisions • temporary emergency guardian for healthcare decisions A *Substitute Healthcare Decision Maker* is anyone authorized, by statute or common law, to make decisions on behalf of another person for medical treatment. A *Permanent Limited Guardian for Health Care Decisions* is a fiduciary named by court order to make medical decisions for the person. This guardian may be, but is not limited to a person's parents, siblings, next of kin, court-appointed advocate or court-appointed probate attorney. A *temporary emergency guardian for healthcare decisions* is a person appointed by the court to make medical decisions based on substituted judgment as a guardian for someone else for a fixed period of time, and is usually appointed in an emergency care or urgent care situation. A substitute healthcare decision maker or guardian's decision about healthcare should be guided by what the person would have decided if he or she were capable of making the decision. If that is not known or cannot be determined, the decision should be based on the good faith belief as to the person's best interests, balancing what is important to her/him with what is important for her/him. Healthcare decision makers and guardians are an important part of a person's support team.	***Documentation:*** Copies of medical consent forms must be maintained in the Health Record.

	General Guidelines Related to Medical Consent Except in emergencies, the decision maker or guardian must be notified of appointments with the PCP and other healthcare providers (e.g., psychiatrist, neurologist, etc.) prior to the visit. Consent from the person or his/her medical decision maker/guardian (if there is one) to administer prescribed medications must be obtained prior to starting the medications. The following information is shared or explained to the person and/ or his/her medical decision maker/guardian: • Whenever possible, all medical information should be explained to the person in a way that he or she can understand. • The person and/ or his or her substitute decision-maker must be informed of and consent to all medications, prior to administration. This includes informing the person and/ or his or her substitute decision-maker when medications may have significant side effects or are new or controversial. A plan to track or monitor the medication and its effects must be implemented. Information regarding the risks associated with psychiatric medications should be outlined by the prescribing psychiatrist on the Psychotropic Medication Review form and maintained in the health record. The person and/ or substitute decision-maker needs to know how the physician will monitor side effects. The service coordinator or registered nurse may need to facilitate communication between the person and/ or substitute decision-maker and the physician. • It is the responsibility of all staff supporting a person to know medications' possible side effects and the protocol to follow for reporting any observed side effects. • The service coordinator or registered nurse shall inform the person and/ or substitute decision-maker when tests (other than routine) are ordered, especially if a problem is suspected, and the outcome.	

Standard 7	**Reporting Critical Incidents**	
Incident Reporting: All people supported by DDA will be monitored for neglect, harm or abuse and all suspected incidents reported to DDA's Incident Management Enforcement Unit. ***Applies to:*** All employees of DDA, all individual agencies that provide services to people with intellectual disabilities through funding, contract, or provider agreement with DC Government.	It is DDA's policy to ensure that all people receiving services as part of the DDA service delivery system are protected from neglect, harm, and abuse. It is essential for providers to implement and maintain an incident management system, and report critical incidents to DDA. There are two types of reportable incidents: • Reportable Incident ("RI"): An RI is an event or situation involving a risk, threat or actual event that impacts a person's health or safety that includes, but is not limited to: a. Emergency relocation b. Emergency room or urgent care visit c. Emergency unauthorized use of restrictive controls (that are in a category typically approved by DDS, but that have not been approved for use with this person) d. Fire e. Inappropriate use of approved restraints (no injury) f. Incidents involving the police g. Medication error h. Physical injury i. Property destruction j. Suicide threat k. Vehicle accident l. Other • Serious Reportable Incident ("SRI"): An SRI is an RI that due to its significance, severity, or repeated instance within a period of time, requires immediate response and notification to DDS/DDA. SRIs include, but are not limited to: a. Abuse b. Death c. Exploitation d. Inappropriate use of approved restraints that results in injury e. Missing person f. Neglect g. Repeated emergency use of restrictive controls	***Documentation*** Incident reports are never part of the medical record. Incident reports are to be filed with DDA via MCIS. Follow agency procedures when filing copies of incident reports within an agency.

	h. Serious medication error i. Serious physical injury j. Suicide attempt k. Use of unapproved restraints l. Unplanned or emergency inpatient hospitalization m. Other Source: *DDS Incident Management and Enforcement Policy and Procedures*	

Standard 8	**Behavioral Support Plan**	
Positive Behavior Support: All community provider agencies shall have a written policy and procedure for behavior support that utilizes individualized positive behavior support and prohibits aversive practices. ***Applies to:*** All DDS employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide service and supports to people with intellectual disabilities.	A positive behavior support plan (BSP) *shall* be developed to support a person in any of the following circumstances: 1. A person exhibits behaviors that pose a threat to his or her health or safety, or to the health and safety of others. 2. Psychotropic medication is prescribed to affect or alter thought processes, mood, sleep, or behavior, with the exception that a person who is prescribed a single psychotropic medication may request exemption in accordance with the criteria and protocol described below. 3. Use of any restrictive control is recommended for the person. A restrictive control is any device, procedure, protocol, or action that restricts, limits, or otherwise negatively impacts a person's freedom of movement, control over his or her own body, and/or access to tangibles/intangibles normally available to people in the community or privacy. 4. A person uses medication as sedation prior to medical and/ or dental appointments. A BSP *may* be developed to support a person in any of the following circumstances: 1. Behaviors are exhibited which interfere with the attainment of learning goals, community integration, or other personal outcomes identified through the person's Individual Support Plan ("ISP") process. 2. Behaviors are a form of communication and alternative forms of communication need to be understood and established. A person who takes a single medication to treat a psychiatric illness, who meets specific criteria described in the DDA Behavior Support Policy may request exemption from the requirement that he or she have a BSP. A BSP is not required for any person who is taking medication solely for treatment of non-psychiatric medical conditions including, but not limited, to Dementia, End of Life palliative care; Cerebral Palsy or other neurodegenerative disorders.	***Documentation*** Documentation of a functional assessment of behavior, and the Behavioral Support Plan (BSP), will be maintained in a separate section of the Health Record. Per DDS policy, a copy will be maintained in an easy to access record for staff to refer to the plan as needed.

	One-time basis medication administered by a physician for sedation during a non-recurring medical appointment does not require a BSP or physician's order but must be documented with a critical incident report. The incident report shall include the name and dosages of medications given on the one-time basis, a description of the person's behaviors as well as documentation of less intrusive interventions tried prior to medication administration. Follow-up by supervisory staff must occur. The decision to develop a BSP must be made by the support team in conjunction with the person and/or his/her guardian. BSPs shall be developed by a licensed psychologist, clinical social worker, licensed professional counselor, or behavior management specialist, in conjunction with the person's support team and must be integrated into the person's ISP. Prior to the development of a BSP, informed consent must be obtained from the person or his/her legal representative to conduct a functional assessment of each behavioral concern. The functional assessment must be performed based on information provided by one or more people who know the person well. The components of a functional behavioral assessment and BSP, along with the provider implementation guidelines, are outlined in the DDA Behavior Support Policy and corresponding procedures. The registered nurse needs to be familiar with the content of the psychological assessment including the functional behavioral assessment and the behavioral support plan in order to incorporate the findings in the Health Care Management Plan. For example, target behaviors identified in the BSP should be part of the expected outcomes for the individual. The nurse also needs to consider the impact of a person's behavior on their overall health care, including adherence to recommended dietary guidelines, participation in health promotion activities, and readiness to make lifestyle changes when needed.	

Standard 9 ***Restrictive Procedures:*** The use of restrictive interventions is a last resort to modify behavior that presents a danger to oneself or others and shall only be used as a behavior change technique if included in a Positive Behavior Support Plan. ***Applies to:*** All people receiving supports through DDA	**Restrictive Procedures** A restrictive control is any device, procedure, protocol, or action that restricts, limits, or otherwise negatively impacts a person's freedom of movement, control over his or her own body, and access to tangibles/intangibles normally available to individuals in the community or privacy. People with intellectual and developmental disabilities shall be supported with only the most proactive, least restrictive, and most effective interventions. When non-restrictive strategies have not successfully protected the person, other persons, or property from harm, the use of restrictive controls may be considered to safeguard people and property only when: 1. A person's health or safety is at risk; 2. It is the only way to protect a person or other people from harm; 3. It is the only way to prevent the serious destruction of property; 4. A physician orders such an intervention as a health-related protection of the person during a specific medical or surgical procedure; or to ensure the person's protection during the time a medical condition is present; or 5. When court ordered. When the health or safety of the person or other persons is at risk or there is danger of serious property destruction, restrictive controls may be implemented incrementally just sufficient to eliminate the imminent risk of harm. The restrictive control shall constitute the least restrictive intervention. The least restrictive control is considered achieved when less intrusive alterations/interventions are not as effective in protecting the individual or others from harm or preventing property destruction. In the event there is no time to attempt less restrictive measure, the emergency use of restrictive controls is permitted on a time-limited basis when: 1. A person's health or safety is at imminent risk; 2. It is the only way to protect a person or other people from harm; or 3. It is the only way to prevent the serious destruction of	***Documentation:*** Documentation of the approval of the use of restrictive procedures by the agency's human rights committee will be maintained in the Health Record.

	property. The emergency use of physical restraint is limited to a cumulative total of 30 minutes within a 2 hour time. After 30 cumulative minutes within 2 hours, the provider shall call 911 or take the person to the emergency room for assessment. The use of restrictive controls, as well as all attempts to use less restrictive methods, must be documented. Use of restrictive controls must also be reported in accordance with the DDS Incident Reporting procedures. All restrictive physical interventions shall have undergone intense scrutiny to provide an approach that balances the safety and rights of the person exhibiting the behavior with the safety of others involved in the situation. Specifically, BSPs with restrictive control procedures must be reviewed and approved by: a. The person or his or her substitute healthcare decision-maker; b. The person's support team; c. The provider's Human Rights Committee; d. The DDS Restrictive Control Review Committee. All community provider agencies shall have and implement a written policy for restrictive behaviors in accordance with the following DDA's Behavior Support and Human Rights policies and corresponding procedures.	

Standard 10 ***Universal Precautions/ Bloodborne Pathogen Training:*** It is a federal requirement that Bloodbourne Pathogen training be presented to employees with the potential for occupational exposure. This training must be provided in accordance with the requirements of the Occupational, Safety, and Health Administration (OSHA). Designated agencies must have written policies consistent with OSHA rules. ***Applies to:*** All DDA employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide service and supports to people with disabilities.	**Universal Precautions/ Bloodborne Pathogen Training** "Universal precautions," as defined by CDC, are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), Hepatitis B virus (HBV), and other bloodbourne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other bloodbourne pathogens. The term, *bloodbourne pathogens*, refers to pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV). All agencies must comply with Occupational, Safety, and Health Administration (OSHA) requirements related to bloodbourne pathogens and universal precautions. According to OSHA Regulation 29 CFR § 1910.1030, all employer agencies must: • Provide an initial Bloodbourne Pathogen training, and annual retraining, for all employees. • Provide training at no cost to employee and during work hours • Provide additional training if modification of tasks or new task occur that may affect occupational exposure • Make copies of the agency's Exposure Control Plan available to all employees • Offer the Hepatitis B vaccine, at no cost, to all employees with potential exposures, within 10 days of their initial work assignment. • Provide immediate post-exposure evaluation to all employees with an exposure incident • Provide personal protective equipment (e.g. gloves, gowns, masks, as needed. A record of the training and annual retraining for all workers is required. In accordance with OSHA regulations, the Hepatitis B vaccine is offered to DDA employees with potential	***Documentation:*** Documentation of Bloodborne Pathogen training sessions will be maintained in agency training records. A copy of the agency's Exposure Control Plan must be available to all employees.

	exposures. Payment for non-DDA employees is the responsibility of the employer or the person/organization contracting for services. *Source: OSHA Regulation, 29 CFR § 1910.1030*	

Standard 11 ***Management of Infections:*** People with antibiotic resistant bacteria, who do not require hospitalization for an acute infection or comorbid condition, can be safely cared for and managed at home by use of standard universal precautions. The service provider shall ensure that staff receives training regarding MRSA or VRE infection management, and specific concerns for the affected person. People with a MRSA or VRE colonization or infection shall not be refused services based on his or her MRSA or VRE status. ***Applies to:*** People who live in an ICF/IDD. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.	**Management of Infections** **MRSA and VRE** Antibiotic resistant bacteria such as Methicillin Resistant Staph Aureas (MRSA) and Vancomycin Resistant Enterococci (VRE) are the most commonly encountered drug-resistant infections in people residing in non-healthcare facilities, such as long-term care facilities. In recent years, there has been an increased incidence of these infections which can be acquired in both the health care and community settings. In the healthcare setting, MRSA occurs most frequently in people with weakened immune systems, and can occur as a wound infection, urinary tract infection, bloodstream injection, and pneumonia. It is transmitted by direct person-to-person contact, often on the hands of caregivers. In community settings, infections usually manifest as skin infections (pimples and boils) in otherwise healthy people. VRE usually comes from the person's own bowel flora, and can be spread by direct person-to-person contact or on the hands of caregivers. People may have a: • MRSA or VRE "colonization" (the organism is present, but not causing illness) • MRSA or VRE infection (the organism is present and causing illness). The risk factors for both colonization and infection include: severe illness, underlying health conditions (i.e. kidney disease, diabetes, and skin lesions), urinary catheter, repeated hospitalizations, and previous colonization by a drug-resistant organism, and advanced age. People with antibiotic-resistant bacteria, who do not require hospitalization for an acute infection or comorbid condition, can be safely cared for and managed at home by use of standard universal precautions. These management strategies include: • Hand-washing with soap and water after physical contact with the colonized or infected person. • Towels used for drying hands should only be used	***Documentation:*** Information related to management and individual response to treatment will be documented on the HCMP and in the nursing and physician progress notes.

	once • Disposable gloves should be worn if contact with body fluids is expected, and hands should be washed after removing the gloves • Covering draining wounds with bandages • If the person has draining wounds or difficulty controlling bodily fluids - gloves should be worn and attended to in a private room • Linens should be changed and washed on a routine basis • Do not share razors, towels, washcloths, or clothing • The person's environment should be cleaned routinely • Instruct people to observe good hygiene practices People with colonized and/ or infected MRSA/ VRA should be encouraged to participate in their usual social, and therapeutic activates. However, if draining wounds are present they should be covered. *Source: CDC (2004)* *For additional information on MRSA, see brochure in Appendix.* **Clostridium Difficile (C. difficile)** C. difficile is an endotoxin-producing bacillus that is a common cause of antibiotic associated diarrhea. The main symptoms of C. difficile are watery diarrhea, fever, loss of appetite, nausea, and abdominal pain and tenderness. This infection can lead to colitis, toxic megacolon, perforations of the colon, sepsis, and death. At risk persons include those with: antibiotic exposure, long length of stay in the healthcare setting, a serious underlying illness, and immunocompromising conditions. C difficile is shed in feces. Any surface, device, or material (e.g. commodes, bathing tubs, and electronic rectal thermometers) that become contaminated with feces may serve as a reservoir for C difficile spores. C. difficile spores are transferred to people mainly by the hands of healthcare personnel who have touched a contaminated surface or item. Management strategies for C difficile include: • For known or suspected cases – use contact precautions. • Place the person in a private room if available	

	• Perform hand hygiene (soap and water wash has been shown to be more effective than alcohol-based hand rub or soap in preventing spore-forming bacteria) • Use gloves during care • Use gowns if soiling of clothes is likely • Dedicate equipment whenever possible • Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices that are likely to be contaminated with feces and surfaces that are frequently touched. *Source: CDC (2005)* **Hepatitis B** Hepatitis B is a contagious liver disease that results from infection with the Hepatitis B virus. Hepatitis B is spread when blood, semen, or another body fluid from a person infected with the virus enters someone who is not infected. A person can become infected by the virus by activities such as sex with an infected partner; sharing drug-injection equipment; sharing items like razors and toothbrushes with an infected person; direct contact with open sores; and exposure to blood from needlesticks and other sharp instruments. The Hepatitis B virus can survive outside of the body at least 7 days. It is essential to practice Universal Precautions and use OSHA recommended procedures to clean up any blood spills. The best way to prevent Hepatitis B is by getting vaccinated. The CDC recommends the Hepatitis Vaccine for high-risk people including residents and staff of residential and non-residential day facilities for people with intellectual and developmental disabilities. *Source: CDC (2009*)	

Standard 12	**Annual Physical Exam**	
Annual Physical Exam: Annual physical exams are required for all people receiving supports and services from DDA, unless otherwise documented, in writing, by the primary care physician. ***Applies to:*** All people receiving supports and services through DDA.	**Comprehensive Medical Service Delivery:** The medical needs of the person should be addressed by the person's primary care provider. This can include a physician, nurse practitioner or physician's assistant. Annually, the primary care provider should complete a thorough physical assessment as needed for the person's age, gender and general physical health and provide a summary of the assessment and any recommendations in writing. (See Medical Evaluation Form in Appendix.) Consultations with specialists will usually be ordered by the primary care provider, but any changes to the person's medical plan of care should be coordinated with the primary care provider. Documentation from the specialty consult must be shared with the primary care physician. The PCP in turn should document in writing that they have reviewed the results of these consults and any follow-up as recommended by the PCP. Any decision to decline a recommendation should also be documented including rationale. All laboratory and procedural reports should be obtained and placed with the person's record as quickly as possible. The primary care provider must be notified of any laboratory tests not within normal limits. Recommendations for general medical care, specialty care, and medical follow-up should be carried out by the residential service provider, within the time frame prescribed by the physician and/or specialist. Annual medical assessments are to include: • All medical and psychiatric diagnoses • Current medications • Recent illness profile • History • Physical exam • Laboratory test results. The assessment is to be appropriate for the age and gender of the person, and tailored to the special characteristics/needs of the person. The following should be viewed as minimum guideline/standards and not as final goals.	***Documentation:*** Documentation of comprehensive health services including health assessments, lab, diagnostic, and screening tests, and specialty consultations will be maintained in the health record.

	The assessment should include the following: 1. Physician's name, signature and date 2. Complete medical problems list 3. Body systems review with blood pressure and weight; including review of ideal weight range 4. Complete list of prescribed medications, including over-the-counter medication and any other alternative therapy used by the individual 5. A list of lab, diagnostic or preventative screening tests in compliance with the US Preventative Health Task Force (See Annual Preventive Health Screening Report). 6. Any recommendations made by the primary care provider The service coordinator will provide a list of medical providers for those who do not have a primary care physician. **Suggestions to Prepare for the Annual Physical Exam:** • When making an appointment for an annual physical, alert the health care provider's office that the appointment is for an annual exam so that sufficient time is allowed. • The behavioral reaction of the person to physical examinations needs to be considered. Strategies to ensure a successful physical exam should begin with educational and positive behavioral approaches before consideration of sedation. • Update the *health passport* and bring it to the appointment. Discuss the need for any screening tests. • Update Annual Preventive Health Screening Report and bring it to the medical appointment so the primary care provider can determine what if any preventative health screenings are needed. • Review the immunization information on the *health passport* and discuss the need for updates with the primary care provider. • Copies of all reports from other physicians such as specialists, emergency room episodes, etc., should accompany the person on the appointment for his or her annual physical exam. Source: Suggestions to Prepare for the Annual Physical Exam - *Vermont Health and Wellness Guidelines (2004).*	

Standard 13 ***Dental Exam:*** Semiannual dental examinations and cleanings (or as specified by the dentist) are required by DDA policy and recommended by the American Dental Association. ***Applies to:*** All people receiving supports and services through DDA	**Dental Exam** Persons' dental needs should be addressed by their primary dentist. A list of dental practitioners can be obtained at http://www.gucchdgeorgetown.net/ucedd/DDA/oral-health-providers.html The following are to be viewed as the minimal standards/guidelines for dental care, and not final goals: 1. Preventative dental care consisting of at least two annual dental exams for persons with natural teeth. This should include the charting of individual restorations, carious lesions (cavities), and other significant information pertaining to periodontal health as well as other conditions of the mouth. A treatment plan must be developed outlining specific dental needs which require interventions, monitoring, or referral to a specialist. 2. Radiographs (x-rays) are recommended once or twice annually for basic evaluation purposes, and as indicated by the dentist or dental specialist. 3. Scaling/prophylaxis should be performed at least twice annually for persons with natural dentition and minor intervention. Persons with periodontal disease will require a minimum of 3 visits per year, at least one of which may be a deep scaling with local anesthesia. 4. One or two soft tissue evaluations are recommended for persons without natural teeth, at which dentures should be evaluated for stability, retention, and function. Additional visits may be required to adjust denture comfort on an as needed basis. 5. Full mouth rehabilitation (comprehensive treatment of all existing dental needs) under general anesthesia for persons requiring this method of service, delivery is not recommended more than every three years. For people residing in ICF/IIDs and those supported through the HCBW – dental services must be designated in the ISP and prior authorization for dental services must be obtained	***Documentation:*** Documentation of dental care and specialty consultations will be maintained in the health record.

	from the Department of Health Care Finance (DHCF). DDA service coordinators facilitate the process of securing prior authorization. Residential providers have a responsibility to ensure that these authorization requests occur in a timely manner.	

Standard 14 ***Hearing & Hearing Aids:*** Support teams need to be observant for changes in behavior that may signal a hearing problem. People with Down syndrome require periodic assessment. Hearing aids, if prescribed, require ongoing maintenance for safe and effective use. ***Applies to:*** All people receiving supports and services through DDA.	**Hearing Screening & Hearing Aids** Good hearing is vital to a person's quality of life. The U.S. Preventive Services Task Force does not recommend annual screening for hearing. However, support teams need to be observant for signs of decreased hearing and make recommendations for appropriate assessment. Information about a person's hearing can be elicited during the annual nursing assessment either by direct observation or questioning the person or their support staff. If there is a question about a person's hearing, they need to be referred to an audiologist and/or ENT physician for an evaluation. Special care should be taken for older adults if: • Behavioral changes are noted. • Hearing loss interferes with quality of life. • Hearing loss is accompanied by an earache, ear discharge, or tinnitus (a ringing in the ears, dizziness or balance problems). People with Down syndrome should have auditory testing every two years because of the frequency with which they experience hearing loss. Hearing Aids People may need support to use hearing aids as prescribed including the development of a behavioral support plan. Hearing aids also require care. Details regarding correct and safe wearing, cleaning and maintenance, and troubleshooting problems accompany the owner's manual and need to be available for reference. Regular and routine checks of the hearing aids, including battery checks and changes, are needed. Refer to the Adaptive Equipment Manual for additional information on the maintenance of hearing aids.	***Documentation:*** Documentation of hearing screenings and audiological recommendations will be maintained in the health record.

Standard 15 ***Vision/Eye Health Care:*** People should receive vision screening if a problem is detected through observation of their interaction with their environment. People with Down Syndrom require exams every 2 years. ***Applies to:*** People who are living in an ICF/IDD. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.	**Vision/Eye Health Care** Visual problems are more in common in adults with intellectual disabilities, but they are also less likely to report changes. Vision problems may have a disproportionate impact on adults who rely on sensory input to compensate for some of their intellectual disabilities. The U.S. Preventive Services Task Force does not recommend screening during the annual primary care visit. With the exception of people with Down Syndrome who have an increased risk of keratoconus and cataracts and should receive an ophthalmologic exam every two years, other adults should receive an eye exam if a problem is noted with their vision. Information about a person's vision can be elicited during the annual nursing assessment either by direct observation or questioning the person or their support staff. If there is a question about the acuity of a person's vision, they need to be referred to an optometrist for an evaluation. If someone is prescribed eyeglasses, please refer to the Adaptive Equipment Manual for suggestions for proper maintenance.	***Documentation:*** Documentation of eye health is part of the annual nursing assessment and progress notes for any acute event.

Standard 16 ***Immunizations:*** People will receive immunizations according to the CDC Adult Immunization Schedule for adult immunizations. Immunization records are to be maintained in the person's file as part of the *Health Passport*. ***Applies to:*** People who live in an ICF/IDD. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.	**Immunizations** Immunizations for vaccine-preventable diseases are vital to health and safety. Immunization decisions should be based on the Centers for Disease Control and Prevention Adult Immunization Schedule Recommendations, in conjunction with the person's primary medical care provider. It is essential to check for updates or changes to the Schedule Recommendations. A current copy of the "Vaccine Administration Record for Adults" needs to be maintained as part of the *Health Passport* in the person's health record. The Adult Immunization Schedule Recommendations are available at http://www.cdc.gov/vaccines/schedules/hcp/adult.html, and are incorporated by reference. Suggested format for documenting the vaccination record is available at http://www.immunize.org/catg.d/p2023.pdf Source: *CDC Adult Immunization Schedules.*	***Documentation:*** Immunization documentation will be maintained on an immunization record form as part of the *Health Passport.*

Standard 17 ***Medication Prescription & Administration:*** All people will receive or self-administer medications in a safe, timely manner in home and community settings. ***Applies to:*** People who are living in an ICF/IID. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.	**Medication Prescription and Administration** **Note: See additional information in Section 18 that specifically addresses Psychotropic Medications.** **Medication Prescription** 1. Medication orders must include the person's name, name of the medication, name and telephone number of the licensed health care practitioner, time of administration, dosage, method of administration, and duration of medication. 2. All prescription medications, not including psychotropic medications used for behavioral purposes, are reviewed and renewed annually at the time of the annual physical exam or as indicated by the physician or practitioner. Prescriptions for psychotropic drugs must be re-prescribed every 30 days. 3. A change in medication dosage requires a new prescription with a written order by the licensed physician/practitioner. 4. Only a licensed nurse (RN or LPN) shall accept a telephone medication order from a licensed physician/practitioner for a new prescription or change in dosage or frequency. 5. PRN medications are medications that are ordered by the physician /practitioner to be administered on an "as needed" basis according to specific written parameters by the physician/practitioner. Parameters must include the necessity for administration, the time/frequency/conditions under which to administer the medication, conditions under which the prescribing practitioner should be notified (i.e., the medication is not effective and/or the person's symptoms are growing more severe. 6. For people taking prescription medications, all other medications, including over-the-counter medication, must also be approved by the physician/practitioner. The pharmacist should be informed of any over-the-counter medications because they may interact with prescription medications.	***Documentation*** Medication administration will be documented in the MAR (Medication Administration Record) for people who live in an ICF/IID.

	7. All medications and dosages should be checked for accuracy at the time of purchase. 8. The supervisory registered nurse, for the person's program, shall obtain and maintain on file at the program's facility and where the person most often receives medications, instructions written by the licensed practitioner to include the name and strength of medication; name and telephone number of prescribing physician/practitioner time, dosage, method of administration, and during of medication; compatibility with other prescribed and non-prescription medications; known program participant allergies; medication usage warnings; side effects; and other potential adverse reactions. 9. A current list of medications including the diagnoses and/or symptoms for which medications are prescribed must be documented on the both the Medication Administration Record (MAR) and the *Health Passport*. **Medication Administration** 1. All medications must be administered as ordered. Medication administration records (MAR) are required for all people who are not self-medicating. The MAR must include a clear record of medication name, dosage, time of administration and signature and title of the person(s) who administered the medication. 2. If medication errors occur, the nature of the error is to be documented with a critical incident report. 3. PRN medications must be documented on the medication administration sheets, and include the name and dosage, the time administered. The reason for use and effectiveness of the medication should be noted in a progress note including a follow-up entry to document the medication's effectiveness. 4. Prescription PRN medications require assessment by a nurse or the prescribing physician/practitioner prior to its administration by a Trained Medication Employee. 5. Medications are to be stored in original pharmacy containers, which are to be stored in a locked cabinet or refrigerator (according to the package insert). Non-oral medications are to be stored separately from oral medications. Medications considered part of a first aid kit,	

	will be stored with the first aid kit and not locked with the medications. 6. The supervisory RN shall review practitioner's orders, Medication Administration Record ("MAR"), and medication intervals for all program participants on a monthly basis. **Self-medication** People who indicate the desire and demonstrate the ability to do so may administer their own medications. An assessment based on recognized standards for self-medication should be used, with any accommodations the person needs specifically noted. A registered nurse must assess knowledge and skills, monitor self-administration of medications, and determine the frequency of review/reassessment. Documentation of this assessment is required if the agency has a role in health services. Source: *DC Code 21-1202* Service Coordinators can consult with DDA Health and Wellness nurses if assistance is needed for self-medication assessment. *For information on self-medication, see Self-Medication Assessment Tool in Appendix*. 1. For people who self-administer medication, a basic record of medication documentation will be maintained in the home. 2. Direct care staff will not administer medications, but may offer a reminder to people when it is time to self-administer. **Training and Monitoring** Trained Medication Employees (TMEs) are individuals who have successfully completed a medication administration course approved by the District of Columbia Board of Nursing, and are certified to administer medications to program participants. 1. TMEs are supervised by registered nurse on an ongoing basis. The supervisory registered nurse shall be available to	

	the TME for general or direct supervision. 2. Prior to administering mediation to a program participant, all TMEs shall: • Observe a registered nurse administering medication on at least two (2) occasions • Be observed by a registered nurse on at least four (4) separate occasions • Demonstrate proficiency and knowledge for all program policies pertaining to medications • Demonstrate knowledge of medications to be administered 3. A registered nurse shall observe, review, and evaluate in writing the ability of the TME to properly administer, document, and store medication for a program participant every three (3) months for the first year of certification and every six (6) months thereafter. 4. All new medications/treatments and first dose medications must be transcribed on the MAR and administered by a licensed practical or registered nurse. TMEs are allowed to copy from one MAR to another; however, before its use, a licensed nurse must review for proper and accurate documentation and sign. 5. The provider facility must maintain a copy of the TME training records to include the RN observations and TME certification. TMEs must have direct telecommunication access to the supervisory RN at all times. Policies and procedures shall be established to ensure staffing ratios are not jeopardized. 6. The supervisory registered nurse is responsible for ongoing monitoring of all people who administer medications to insure safe medication administration practices - documentation of this monitoring is required. (DC Board of Nursing Delegation) Source: *DC Code 21-1201-12061 and the DC Municipal Regulations for Trained Medication Employees (TMEs).*	

Standard 18	**Psychotropic Medications**	
Psychotropic Medications: All psychotropic medications are administered in a manner to ensure that people benefit from their use and that their rights, health, and well-being are protected. All people will have appropriate access to information and treatment with psychoactive medications, and shall have reasonable protection from serious side effects or the inappropriate use of these medications. ***Applies to:*** All DDS employees, providers/vendors, community representatives, government entities and individuals who provide support or services to people receiving services and supports from DDA.	Psychotropic medications when used should strive to find a minimal effective dose, and be part of an overall treatment strategy that includes psychosocial treatment interventions. These interventions include the identification and management of stressors, changes needed in the environment, teaching people and caregivers and other treatment approaches such as cognitive-behavioral therapy. DDS has adopted the following standards: • A licensed, board-certified psychiatrist must make all decisions: a) if a person should undergo a formal assessment for a mental disorder; b) if the person is likely to benefit from taking a psychotropic medication; and c) the prescription, administration, monitoring, and oversight of such medications. • Psychotropic medication shall only be prescribed to people with intellectual and developmental disabilities that have a formal psychiatric assessment and a diagnosed mental disorder. Documentation from the provider will be required acknowledging the psychiatric assessment recommendations for psychotropic medication use for the person. The plan must be incorporated into the ISP, and a behavioral support plan will be in place prior to the prescription of the medication(s). • The concept of "minimal effective dose" (MED) needs to be reflected in medication orders. This term refers to use of the lowest dose of medication that produces the desired effect. • Prescribing practitioners shall assess people for abnormal movement disorders as follows: o Any person not currently taking a neuroleptic medication shall receive a baseline screening under the following circumstances: ▪ upon recommendation for treatment with neuroleptic medication, prior to the administration of the drug or ▪ upon admission to a DDS-operated, funded, or licensed facility or program if the individual has a recent **history (i.e. within the past 6 months)** of	***Documentation:*** The psychotropic drug review form will be used to document the interdisciplinary review of prescriptions for psychotropic medications. The critical incident report will be completed when medications are administered on a one-time basis to address a psychiatric health problem.

	previously taking neuroleptic medication. o All people currently taking neuroleptic medication shall be assessed at least semiannually or more frequently as necessary by symptom assessment or determined by the prescribing practitioner. o Any person currently taking a neuroleptic medication who is newly admitted to a DDS-operated, funded, or licensed facility shall have an initial screening within one month of admission. o Any person whose neuroleptic medication is discontinued shall be screened after the discontinuation at the following intervals: ▪ one month ▪ three months, or ▪ whenever the prescribing practitioner determines and documents that the person does not have TD **NOTE**: In rare instances, withdrawal movement disorders can emerge after three months following the discontinuation of a neuroleptic medication. This is likelier following the use of a long acting, injectable neuroleptic. If movements are observed after the three-month screening, the person should be referred to the prescribing practitioner for assessment. • All screenings and/or prescribing practitioner assessments, diagnoses and treatment plans shall be documented in the person's medical record. • People showing signs of TD should be considered for referral to an appropriate specialist (i.e., neurologist) by the prescribing practitioner for the purpose of evaluation, diagnosis, and treatment recommendations. • When a person is diagnosed with TD, the following shall occur: o Documentation of the diagnosis on Axis III. o The prescribing practitioner shall notify the person's service coordinator or nurse of the diagnosis and treatment recommendations. o The service coordinator or nurse shall notify	

	the person's support team, family, if appropriate, guardian, advocate, and the DDS Health and Wellness Unit. o The support team shall meet within 30 days of the notification and shall ensure that all appropriate recommendations are provided and documented in the person's health file. • If person is diagnosed with tardive dyskinesia (TD), the treatment team including the prescribing practitioner, shall examine the risk versus benefit for this person and consider the necessity for continuing the medication. o When a decision is made to discontinue or reduce a neuroleptic medication, the treatment team will be informed of the recommendations for dose reductions and discontinuation of the neuroleptic medication. o When a decision is made not to reduce or discontinue the neuroleptic medication, the treatment team must ensure that documentation details the following: ▪ the risks versus benefits of continuing the neuroleptic medication and ▪ the consent for the medication clearly states that the person will continue to take the medication even though TD has been diagnosed. • A support team review of the use of psychotropic medications must be completed at a minimum of every 90 days, but the frequency of reviews should be determined by the person's clinical status. • Psychotropic medications must be renewed by a physician or nurse practitioner every 30 days. • The DDS Psychotropic Review Form should be used to document mental health diagnoses, labs, status of current health concerns, side effect monitoring, and medication changes.	

	Please refer to the Appendix for: "***A CHECKLIST FOR COORDINATORS AND SUPERVISORS: Psychiatric and Behavioral Problems in Individuals with Intellectual Disability".*** This checklist is based on "***Treatment of Psychiatric and Behavioral Problems in Individuals with Mental Retardation: An Update of the Expert Consensus Guidelines"*** by MC Aman, ML Crismon, A Frances, B H King and J Rojahn. The checklist, which was based on the recommendations of a panel of national experts, was developed for Service Coordinators, Program Managers, QDDP's and others who coordinate and supervise care for people with an intellectual disability. It was adapted from the guidelines with permission of the publisher. The Checklist is also available at: http://www.gucchdgeorgetown.net/ucedd/DDA/documents/Checklist-for-Coordinators-&-Supervisors.pdf Source*: DDS Policy* 1. Behavior Support policy 2. Behavior Support Plan procedure 3. Behavior Support Plan Safeguards & Oversight procedure 4. Human Rights Policy 5. Provider Human Rights Committee procedure 6. Restrictive Control Review Committee procedure	

Standard 19	**Psychiatric Services**	
Psychiatric Services: Psychiatric assessment and treatment will be available for people with known or suspected psychiatric disorders. Licensed psychiatrists shall provide assessment, diagnosis and treatment of psychiatric disorders. ***Applies to:*** All people receiving supports and services through DDA	Psychiatric services, like all other specialty services, need to be coordinated within the framework of the support team, including the PCP. For psychiatric care to be effective, strong communication must be maintained so that the prescribing psychiatrist has the complete data from which to make an accurate diagnosis, plan for treatment (including non-pharmacologic approaches), assess for the effectiveness of prescribed medications, and to assess for deleterious side effects. Each person who is prescribed psychotropic medications for more than a one-time basis shall have an annual psychiatric assessment (The DDS required Annual Psychiatric Template is attached as Appendix Item 18). One-time basis medication administered by a physician for sedation during a non-recurring medical appointment does not require an annual psychiatric assessment. Support teams need a uniform way of documenting the review of behavioral and laboratory data as well as screening for side effects. DDA requires the adoption of the Psychotropic Medication Review Form (See Appendix Item 9). 1. Psychiatrists require current descriptions of the person's behavior in order to make informed prescribing decisions. Either page 2 of the Psychotropic Review Form or a behavioral note must be provided at each psychiatry appointment and shall provide a description of target behaviors that have occurred since the last psychiatry appointment. Page 2 of the Psychotropic Review Form or the behavioral note shall also summarize changes in the person's functioning in the following areas since the last psychiatry appointment. Activity Level (increased or decreased) 2. Psychiatric symptoms 3. Unusual Body Movements (i.e., tremors) 4. Anxiety 5. Sleep Changes	***Documentation:*** Psychiatric services will be documented in the physician progress notes, consultation forms, and the psychotropic medication review form.

	6. Appetite changes (Increased or decreased) 7. Change in Mood 8. Suicidal ideation/behavior 9. Major life changes/stressors 10. Environmental Issues 11. Psychotic symptoms 12. Medication side effects 13. Incidents related to the individual's mental health diagnosis or target symptoms including, but not limited to: a) ER visits b) Psychiatric hospitalizations c) Use of restraints d) Police calls Page 2 of the Psychotropic Review Form or the behavioral note should be reviewed by the person's nursing staff prior to the appointment.	

Standard 20 ***Therapeutic Services*:** Therapeutic services, such as physical therapy, occupational therapy, nutrition and speech/language therapy services, are to be supported by evidenced-based practice. ***Applies to:*** All people receiving services through DDA.	**Therapeutic Services:** **Physical, Occupational, Nutrition and Speech & Language Therapies** Evidence-based practice therapeutic services include the integration of the best available research, clinical expertise, and patient values and circumstances related to client management (American Physical Therapy Association, 2009). **Physical Therapy** Physical therapy services are available to diagnose, manage, and treat disorders of the musculoskeletal system. Physical therapists work with people to address problems with ambulation, balance, positioning, and loss of functional independence. The goal of physical is to restore maximal functional independence. **Occupational Therapy** Occupational therapy services are available to assist people with the development, recovery, or maintenance of daily living and work skills. Occupational therapists work to support a person's ability to engage in everyday activities and acquire new skills to promote function. The goal of occupational therapy is to assist people in developing independent, productive, and satisfying lives. To be eligible for reimbursement, Physical therapy and Occupational therapy services must be: • Ordered by a person's PCP • Be reasonable and necessary for the treatment of the person's illness, injury, or long-term disability • Be included in the ISP The physical therapist and/or occupational therapist, at a minimum, will: • Prepare a report summarizing the physician order, measures of strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor functions. • Prepare a treatment plan that will develop and describe treatment strategies including direct therapy; training caregivers; monitoring equipment requirements and instruments; monitoring instructions; and anticipated outcomes. • Maintain ongoing involvement and consultation with	***Documentation:*** The physician order for therapeutic services shall be maintained in the Health Record. Written documentation by therapists in the forms of reports, assessments, visitation notes, and progress notes are to be maintained in the Health Record. Weight logs are a part of the nutritional record and should be maintained along with other nutritional information in the Health Record. The frequency of weight measurements is determined by the nutritional services provider, physician, and/or registered nurse.

	other service providers and caregivers • Ensure the person's needs are met in accordance to the physician order • Provide consultation and instruction to the person, family, and/or other caregivers • Record a progress note on each visit • Conduct periodic examinations modifying treatments for the person, when necessary • Provide written documentation of the person's progress (or lack thereof), medical conditions, functional losses, and treatment goals that demonstrate that physical therapy services are reasonable and necessary. Source: *District of Columbia DCMR Title 29, Chapter 9, Section 934 (Physical Therapy) and 935 (Occupational Therapy)* **Nutrition** Good nutrition is a vital part of each person's quality of life. People should be guided in learning about the components of a healthy diet, keeping in mind one's personal, cultural, and ethnic preferences. Many resources exist in the community to educate people and their support team. Examples include: community education courses at recreation centers, senior centers, churches, and hospitals. For underweight, overweight, or obese people, interventions to promote and sustain optimal weight should be discussed with the person's primary care physician. What is important to the person and person centered approaches to address the weight concerns should be explored prior to medical intervention. When medical intervention is needed, the primary care provider will order a referral to a registered dietician or nutritionist. The dietician or nutritionist may develop a therapeutic diet to address weight gain, weight loss, allergies, cholesterol, etc., which require an order by a primary care provider. It is the responsibility of the support team to advocate that person has a balance between what is important to and for him/her in the therapeutic diet. All support team members must be aware of the dietary protocol, the effectiveness of the diet, and any barriers to following the protocol (refusals of meals, behaviors that occur with the diet changes, etc.) should be tracked by	

	weight charts and a meal time diary. Weight records are kept for a person if a need is determined by the Health Care Management Plan or a primary care provider order (e.g., underweight or overweight, to track chronic weight maintenance; for medications and/or treatments which may affect weight changes, etc.). People who receive gastric tube feedings with prescribed nutritional input from a physician or dietician, or have a history of underweight status, need weight tracking to ensure maintenance of adequate weight range. It is important to keep accurate weight records. Weight measurements should be obtained on a regular basis, in the same setting, and under the same circumstances to ensure accuracy. ICF/IID regulations require a minimum of quarterly evaluations by a registered dietician. For people living independently service coordinators must be aware during their monthly visits of changes to the person's nutritional habits or weight. If obvious changes are apparent in weight, the person should be referred to the PCP for an initial assessment. Subsequent to the PCP's recommendation, such strategies as weight monitoring or referral to a community-based weight management program may be needed. The service coordinator should also note food availability and the reliance on take-out food that may indicate the need for education and support in food shopping, meal preparation or dietary counseling. Note: ICF/IID regulations stipulate that only licensed dieticians can provide services. This excludes nutritionists. The HCBS Waiver, however, does fund both licensed dieticians and nutritionists. **Speech and Language Services** Speech and language services are available to assess, diagnose, treat, and prevent disorders related to speech, language, cognitive communication, voice, swallowing, and fluency. Speech-language pathologists help patients develop, or recover, reliable communication and swallowing skills so patients can fulfill their educational, vocational, and social roles.	

	To be eligible for reimbursement, speech, hearing, and language services must be: • Ordered by a physician if the person has any history of aspiration, swallowing problems, tube feedings, or other medical issues • Recommended by the support team if the issues are not medical • Be reasonable and necessary for the treatment of the person's illness, injury, or long-term disability • Be included and written into the ISP Speech, hearing, and language services may be used to: • Address swallowing disorders • Assess communication disorders • Assess potential for clearer speech • Assess potential for use of augmentative and alternative speech devices, methods, or strategies • Assess potential for sign language or other expressive communication methods • Conduct environmental reviews of communication in places of employment, residence, or other sites • Assist with recovery from a vocal disorder • Speech, language, and hearing services shall include, as necessary, the following: • A comprehensive assessment to determine the presence or absence of a swallowing disorder • A comprehensive assessment of communication disorders • A background review and current functional review of communication capabilities in different environments • A needs assessment for the use of augmentative and alternative speech devices, methods, or strategies • A needs assessment for use of adaptive eating equipment • Assist persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production • Aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss The speech, hearing, and language service provider will be responsible for providing: • Written documentation in the form of reports,	

	assessments, physician orders, visitation notes, progress notes, and other pertinent documentation of the person's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the services are and continue to be reasonable and necessary. Source*: District of Columbia DCMR Title 29, Chapter 9, Section 932 (Speech, Hearing, and Language Services)*	

Standard 21 ***Lifestyle Changes*:** The Stages of Change describes five stages of readiness and provides a framework for understanding the change process. By identifying where a person is in the change cycle, interventions can be tailored to the individual's "readiness" to progress in the recovery process. Interventions that do not match the person's readiness are less likely to succeed and more likely to damage rapport, create resistance, and impede change. Anything that moves a person through the stages toward a positive outcome should be regarded as a success. ***Applies to:*** All people receiving services through DDA.	**Supporting Lifestyle Changes That Promote Health** For people whose health would benefit from a lifestyle change (*e.g.*, quitting smoking, losing weight or reducing or eliminating alcohol intake), support teams should be familiar with the *Stages of Change* model. An emphasis on what people refuse to do focuses on failure and is discouraging for both the person who could benefit from the lifestyle change and the health practitioners and other support team members. When a health risk is identified that could benefit from a lifestyle change, the support team must assess where the person is along a continuum of change. Lifestyle changes rarely occur as an isolated event. While there is little research in the application of these principles for people with intellectual disabilities, for most people with mild cognitive limitations and better adaptive functioning, these principles should be successful. The stages of change include: **PRECONTEMPLATION STAGE** During the precontemplation stage, people do not even consider changing. Smokers who are "in denial" may not see that the advice applies to them personally. People with high cholesterol levels may feel "immune" to the health problems that strike others. Obese people may have tried unsuccessfully so many times to lose weight that they have simply given up. **CONTEMPLATION STAGE** During the contemplation stage, people are ambivalent about changing. Giving up an enjoyed behavior causes them to feel a sense of loss despite the perceived gain. During this stage, people assess barriers (e.g., time, expense, hassle, fear, "I know I need to, doc, but …") as well as the benefits of change. **PREPARATION STAGE** During the preparation stage, people prepare to make a specific change. They may experiment with small changes as their determination to change increases. For example, sampling low-fat foods may be experimentation with or a move toward greater dietary modification. Switching to a	***Documentation:*** The physician order for lifestyle changes shall be maintained in the Health Record. Written documentation by staff in the form of reports, assessments, visitation notes, and progress notes are to be maintained in the Health Record.

different brand of cigarettes or decreasing their drinking signals that they have decided a change is needed.

ACTION STAGE

The action stage is the one that most physicians are eager to see their patients reach. Many failed New Year's resolutions provide evidence that if the prior stages have been glossed over, action itself is often not enough. Any action taken by patients should be praised because it demonstrates the desire for lifestyle change.

MAINTENANCE AND RELAPSE PREVENTION

Maintenance and relapse prevention involve incorporating the new behavior "over the long haul." Discouragement over occasional "slips" may halt the change process and result in the person giving up. However, most people find themselves "recycling" through the stages of change several times before the change becomes truly established.

By identifying a person's position along this continuum, appropriate interventions can be developed to support movement toward the desired outcome.

For the full article, go to http://www.aafp.org/afp/2000/0301/p1409.html?printable=afpp

Motivational interviewing includes techniques for determining where people are on the change continuum. For more information go to http://www.samhsa.gov/co-occurring/topics/training/skills.aspx

Reference: Zimmerman, Z., Olsen, C. and Bosworth, M. *A 'Stages of Change' Approach to Helping Patients Change Behavior.* American Family Physician, 2000 Mar 1; 61(5): 1409-1416.

Standard 22 ***Seizure Disorders and Protocols:*** People will be appropriately screened for the presence of seizure disorders and receive timely and comprehensive care coordinated by the PCP in consultation with neurologists and other specialists. ***Applies to:*** All people receiving services through DDA	**Seizure Disorders and Protocols** Seizure Disorders or epilepsy is the most common co-morbid medical condition in people with developmental disabilities. The incidence of epilepsy is related to the severity of the intellectual involvement with a rate of 20% in people with mild intellectual disabilities, and can be as high as 50% in people with severe-to-profound intellectual disabilities (Alverez, 2008). Most people with seizure disorders are supported by a neurologist on a timetable prescribed by the neurologist. When a person attends a neurology consultation s/he should bring the following : • a record of seizures from the time of the last appointment • The *Health Passport* noting any changes in medications or diagnoses • Any data reporting recent behavioral changes New Onset Seizures New onset seizures require a medical evaluation, and imaging studies, laboratory tests, and EEG. People with developmental disabilities are living longer than before; therefore the incidence of new-onset seizures is high in people over 60 years of age. In the situation of new onset seizures - trauma, tumors, and infections need to be considered. In people in their late 40s with Down Syndrome, seizures may be seen as an expression of Alzheimer disease (Alverez, 2008). Situations Requiring Medical Evaluations Other situations that would be considered an emergency requiring medical evaluation include: • Seizures that do not stop within five minutes (See Status Epileptics below) • The person's postictal or post-seizure behavior is significantly different from his or her usual postictal state • The person has difficulty breathing • The person was injured during the seizure • The seizure is a first-time seizure • There is a significant change in the type or character of the seizure from that person's usual seizure pattern	***Documentation:*** A record of all seizure activity needs to be maintained in the health record. A copy of this record should accompany individuals to all medical appointments.

	Status Epilepticus (SE) is a common, life threatening disorder. It is essentially an acute, prolonged seizure crisis. While it is usually defined as being 30 minutes of uninterrupted seizure activity, the Epilepsy Foundation recommends that the public call for assistance when a seizure continues for 5 minutes or more without signs of stopping. It also recommends that emergency room physicians regard seizures as status epilepticus if seizures have continued for more than 10 minutes. Rapid and aggressive medical treatment in the hospital is essential. (Epilepsy Foundation, 2009) The most common precipitating factor for SE is a change in medication – either abrupt cessation of medication (i.e. being placed on NPO "nothing by mouth" before a medical procedure or medication not be administered) or non-adherence to seizure medication regimen Source: Cavazos, JE, Spitz M. Seizures and Epilepsy: Overview and Classification. eMedicine from WebMD. Updated November18, 2009. Available at: http://www.emedicine.com/neuro/topic415.htm. A written seizure record needs to be maintained on all people with seizures. A complete seizure record consists of the following information: • Date of seizure • Time of seizure • Antecedent to the seizure • Description of the seizure • Duration of the seizure • Post-seizure status Care provided during and after the seizure activity The Appendix includes two recommended formats for recording seizures.	

Standard 23 *<u>Adaptive Equipment</u>:* All people who are supported by DDA shall receive an initial and ongoing assessment of their need for adaptive equipment. Modifications or repair of adaptive equipment will occur in an expeditious manner. ***<u>Applies to</u>:*** All people supported by DDA.	**Adaptive Equipment** <u>Background</u> Having and being able to use the right adaptive equipment can be an important tool to help people with disabilities maximize their independence and achieve self-determination. Adaptive equipment can empower a person with a disability to communicate more effectively, move about the community more freely, eat with enjoyment and safety, and achieve greater independence. As with all decisions about a person's life, decisions about adaptive equipment should be directed by the person with information and support, as needed, from his or her support team. These should also be reflected in the person's Individual Support Plan (ISP). Adaptive Equipment includes both durable medical equipment (DME) and assistive technology (AT) devices. • DME includes items such as wheelchairs, hospital beds, toilets aides/commodes, canes, walkers, crutches, and other equipment that is used in the person's home, capable of repeated use, and necessary to address the person's medical or physical need. • AT devices include augmentative communication devices, sound amplifiers, TTY devices, Braille devices, computer software, and other customized or modified barrier- reducing equipment. A person's need for adaptive equipment should be continually evaluated, recognizing that a person's needs and abilities may change due to health conditions, aging, physical status, and skills. <u>Assessments</u> A person will always need an assessment by a healthcare professional (i.e. physical therapist, occupational therapist, speech/language clinician, or physician) when any new adaptive equipment needs are identified. Additionally, a person who uses a custom-made wheelchair will always need an assessment by a healthcare professional when it is time to replace that wheelchair. A person who has other adaptive equipment that needs	***<u>Documentation:</u>*** Orders for adaptive equipment and DME need to be noted in the PCP orders. For the adaptive equipment monthly checklist and tracking, please use the system in MCIS.

	replacement or repair may need an assessment by a clinician to verify his or her safety while his or her equipment is being repaired or replaced. The person may also need an assessment to ensure the proper replacement or repairs. Always check with the person's health care professional. Compare, a person who has an assessment on file that indicates the need for a shower chair or adaptive equipment to assist with mealtimes who needs an item replaced; versus someone who uses a custom wheelchair that needs replacement. The person who needs mealtime equipment might not need another assessment. The person using the custom wheelchair will need an assessment to ensure his or her safety while waiting for the new wheelchair, and to ensure that the replacement wheelchair is appropriately customized. Appointments for assessments should be scheduled as soon as possible and must take place no later than 30 days from the time the person's need has been identified. <u>Provider and Service Coordination Responsibilities</u> Each provider staff member who supports a person with a disability must be familiar with all of the adaptive equipment that the person may use. It is the responsibility of Direct Support Professionals, Qualified Developmental Disability Professionals, Program Coordinators, nurses, and other therapists to support the person in using and maintaining his or her adaptive equipment, to conduct routine inspections, cleaning, and maintenance, and to report any problems with the person's adaptive equipment. Each provider staff member is also responsible for following up on problems related to adaptive equipment until the problem is resolved so that the person has the support he or she needs. It is the responsibility of the residential provider, if a person has one, to ensure acquisition, repair and/or replacement of adaptive equipment. For people who live independently or with their family, the person's Service Coordinator, in collaboration with the person and/his or her support network, is responsible for ensuring acquisition, repair and/or replacement of adaptive equipment. Each provider agency is required to have internal protocols that ensure clear responsibilities for employees to support	

	people to use and maintain their adaptive equipment, and to inspect, clean, and maintain adaptive equipment consistent with the DDS Adaptive Equipment Maintenance Protocols. It is recommended that these duties be included within employee's position description. Each provider agency must identify at least one person who will be responsible for tracking the ordering, maintenance and cleaning of adaptive equipment. This employee must participate in the required DDA train the trainer course on the maintenance of adaptive equipment. <u>Process for Submitting Adaptive Equipment Claims</u> For people who receive supports through the Home and Community Based Services waiver, all adaptive equipment claims (custom and non-custom) must be submitted to the person's healthcare insurance company. For people who live in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID), the provider is responsible for purchasing all needed non-custom adaptive equipment (*e.g.*, standard wheelchairs, shower chairs, hospital beds, Hoyer lifts, etc.). ICF/IID providers are required to bill the person's insurance for custom adaptive equipment (*e.g.*, custom wheelchairs, eyeglasses, dentures, etc.). To ensure timely acquisition, repair, and/or replacement of adaptive equipment, insurance claims must be submitted in the proper order, as follows: (1) private insurance, if any; (2) Medicare; (3) Medicaid; (4) D.C. local funds, in accordance with DDA's Utilization of Local Funds to Purchase, Repair, Rent and/ or Lease Adaptive Equipment policy and procedure. Also, please see the DDA Adaptive Equipment Maintenance Protocols.	

Standard 24 ***End-of-Life Planning:*** End-of-life planning is discussed within the context the annual ISP meeting. ***Applies to:*** All people served by DDA.	**End-of-Life Planning** End-of-life decision making is not a single event that occurs in the midst of a critical illness. It is an ongoing series of choices based on life experiences, family and friend support systems, as well as health issues (King and Craig, 2004). As a person's life progresses or as changes occur in a person's health condition, opportunities arise for discussions with the person about end–of-life planning. This approach enables documentation of these conversations and records the person's preferences and values regarding end-of-life treatments and other types of medical care. End-of life planning should occur within a person-centered planning framework. Each person and their health care decision-maker need to decide the extent to which s/he is comfortable in planning. The support team has an obligation to introduce the topic during the annual ISP planning process. The actual planning appropriately takes place outside of the actual ISP meeting. The individual and anyone who supports his or her decision-making will select those individuals he or she wants to be part of the planning process. This can include family members, friends, paid staff, and health care-givers. The DDS service coordinator should ensure any resources needed in plan development are identified. However it must be recognized that some people will choose to forego this process. **Guidance on the Effect of Do Not Resuscitate (DNR) and Do Not Intubate (DNI) Orders** The purpose of this guidance is to provide information on the effect of Do Not Resuscitate (DNR) and Do Not Intubate (DNI) orders once a person who receives supports from the Department of Disability Services (DDS) leaves the hospital and returns to a residential, day or vocational setting. Also included are definitions of commonly used terminology, and information about the Department of Health, Emergency Medical Services, and Comfort Care Order. The Department of Disability Services (DDS) recognizes the complexity and sensitivity of end-of-life decisions. DDS provides information on comfort care orders and resources available to aid persons with disabilities in planning ahead for their end of life decisions so that their planning can be meaningful, individualized and completed based on access to	***Documentation:*** End-of-life discussions, sharing of resources and end-of-life plans must be documented in the Health Record and ISP. This may include meeting minutes that address of end-of-life issues.

	medical information. Many people with intellectual disabilities have the capacity to make decisions about end-of-life care but in some cases, seek the counsel of their significant others, family members, surrogates, friends and decision makers. Below is a list of defined terms and guidelines to DDS contract providers on comfort care orders for people they support. **<u>Definition of Terms</u>** 1. ***What is DNR?*** DNR stands for **"Do Not Resuscitate"** and, when included in an advance directive, instructs medical personnel not to provide cardiopulmonary resuscitation (CPR) if the heart stops or breathing ceases. DDS follows guidelines issued by the Department of Health (see below), which requires that DNRs or any Comfort Care Orders be signed by the person or his or her authorized decision maker. 2. ***What is DNI****?* DNI stands for **"Do Not Intubate"** and, when included in an advance directive, instructs medical personnel that chest compressions and cardiac drugs may be used to revive a person but a breathing tube shall not be placed. DNI orders often accompany or fall under other comfort care orders recognized by the District of Columbia government. 3. ***What is a Do Not Hospitalize (DNH) Order?*** **A "Do Not Hospitalize" order is a** medical order signed by a physician to instruct other health care providers not to transfer a patient to the hospital from a setting such as a nursing facility or the person's home unless needed for comfort care. (Note: specific wording may vary from state to state.) 4. ***What is a Comfort Care Order (CCO)?*** ***A "Comfort Care Order"*** allows patients diagnosed with a specific medical or terminal condition to express their wishes regarding end-of-life resuscitation in the pre- or post-hospital setting. A patient's attending physician must certify and sign a Comfort Care Order (CCO) that states the patient (adult or child) has a specific medical or terminal condition. The	

	patient, or his or her authorized decision maker or surrogate, must also consent and sign the CCO. Please note that verbal orders are not valid. 5. ***What is a Comfort Care Bracelet?*** When a doctor issues a CCO for a patient, they are given a hospital band that identifies them as having a CCO in place (DC DOH). 6. ***How does a DNR work outside of a hospital setting?*** There are three situations involving DNRs of which providers should be aware: 1) DNRs signed during a hospitalization on a hospital form only applies for the duration of that specific hospitalization and do not subsequently apply in the person's residential setting or natural home. If a person signs a DNR at the hospital, the team may want to discuss, upon discharge home, whether the person wants to consider completing an Advance Directive, Living Will or Durable Power of Attorney to keep on file. 2) DNRs signed as a part of an Advance Directive, Living Will or Durable Power of Attorney applies in all settings and should be honored. A hospital may still require the person to sign its specific DNR form as well, to match the person's other signed legal directives. If a person does not have a signed DNR as a part of an Advance Directive, Living Will or Durable Power of Attorney, then the providers should proceed with the usual emergency protocol, including provision of CPR or other life-saving measures. 3) Only Comfort Care bracelets and any comfort care orders (signed by a physician) present in the home will be considered valid and will be honored by Fire/EMS. Please note that Fire/EMS will not honor DNRs signed as a part of an Advance Directive, Living Will or Durable Power of Attorney without a corresponding Comfort Care bracelet for Fire/EMS. Comfort care bracelets are available through the Department of Health.	

	For More Information Please contact the DC CCO-DNR Program at (202) 671-4222 or visit the CCO-DNR website at http://doh.dc.gov/service/ems-comfort-care-order-do-not-resuscitate-program. For more information about supporting people to make end-of-life decisions, please visit the **End-of-Life Decisions for Adults with Significant Intellectual Disabilities** website developed by Georgetown University Center for Child and Human Development and the Department on Disability Services (DDS): http://gucchdgeorgetown.net/ucedd/complex/ *Additional information on End-of-Life planning can be found in the Appendix – see "Thinking Ahead".*	

Standard 25 ***Alternative/ Complementary Therapies:*** The PCP must be consulted prior to the initiation of alternative/complementary therapies. ***Applies to:*** People who are living in an ICF/IID. People enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services. ***Recommended for:*** *People living independently or residing in their family home.*	**Alternative/Complementary Therapies** All alternative and complementary therapies need the input of the PCP prior to implementation. Alternative and complementary healthcare and medical practices are those that are not currently an integral part of conventional healthcare. Conventional healthcare refers to medicine as practiced by individuals who hold a medical doctor (MD) or doctor of osteopathy (DO) degree. Alternative and complementary healthcare and practices may include, but are not limited to, chiropractic therapy, homeopathic and herbal medicines, acupuncture, naturopathy, mind/body therapy, etc. Any alternative or complimentary medication (e.g., herbal or homeopathic) needs to have a written order by the PCP. This documentation must be kept in the person's file.	**Documentation**: All alternative and complementary therapies should be documented in the health record and on the *Health Passport*.

Standard 26 ***Associated Health Conditions In People With Developmental Disabilities*** There are four major health issues associated with people who have a developmental disability. Health risks other than the Fatal Four will require protocols to reduce risks. ***<u>Applies to</u>:*** All people served by DDA.	**Associated Health Conditions In People With Developmental Disabilities** There are four major health issues that are more common in people who have developmental disabilities than in the general population. These four conditions can cause both morbidity and mortality. They are: Aspiration, Constipation, Dehydration, and Epileptic Seizures. Protocols will need to be developed with interventions to follow regarding the health problem. Aspiration, dehydration and constipation may be insidious conditions that often go unrecognized. Many of the symptoms are subtle and persons with disabilities may not be able to express their discomfort or give indications that they are not feeling well. The following information will help nurses identify people with these associated risks and provide guidance on nursing assessments, HCMPs and the development of protocols. A strong defense against theses four conditions can be approached in the following manner to develop person centered interventions: 1. Identifying the person's and healthcare team's learning needs related to the condition. 2. Training to meet the identified learning needs to prevent injury and promote safety that is well communicated among all involved in caring for the person. 3. Identification of current support services in place to prevent or lessen the effect of the condition 4. Identification of pre-planned actions for the person and/or healthcare team to take, should signs or symptoms of the condition develops. **Aspiration** Aspiration is defined as the inhalation of food, fluid, saliva, medication or other foreign material into the trachea and lungs. Any material can be aspirated on the way to the stomach or as stomach contents are refluxed back into the throat. Conditions such as dysphagia can complicate matters even more that will require regular evaluations as specialized by the Speech and Language pathologist (SLP).	***Documentation:*** The associated health condition must be documented in the Health Record, Training Records and ISP. Nursing HCMPs, HP and Assessments much be updated accordingly to status any status changes.

	Factors that place a person at risk for aspiration and will require further evaluation: • The need to be fed by others • Inadequately trained staff assisting with eating/drinking • Weak or absent coughing/gagging reflexes, commonly seen in persons who have cerebral palsy or muscular dystrophy • Poor chewing or swallowing skills • Gastroesophageal reflux disease (GERD) which can cause aspiration of stomach contents • Inappropriate fluid consistency and/or food textures • Medication side effects that cause drowsiness and/or relax muscles causing delayed swallowing and suppression of gag and cough reflexes • Impaired mobility that may leave a person unable to sit upright while eating • Epileptic seizures that may occur during oral intake or failure to position a person on their side after a seizure, allowing oral secretions to enter the airway. **GUIDELINES ON HOW TO PREVENT OR MINIMIZE THE RISK OF ASPIRATION** • Obtain a consultation by a swallowing specialist if symptoms occur • Change diet consistency, texture or temperature (need a physician's order) • Slow the pace of eating and decrease the size of the bites • Position to enhance swallowing during meal times • Keep in an upright position after meals for 45 minutes or as ordered • Sit the person upright in a chair, if confined to bed, elevate the backrest to a 90-degree angle. • Avoid food/fluids 2-3 hours before bedtime • Consider the use of medications to promote stomach emptying, reduce reflux and acidity • A protocol may cover the following: (a) the assistance level needed (b) correct positioning for all	

	oral intake and tooth brushing (c) eating/feeding equipment needed (d) physical and verbal cueing needed € location of meals (some people may need to eat alone as they become distracted when eating with their peers and (f) recognition of aspiration symptoms, what to do about if noted and who to notify. ASPIRATION RISKS AND FEEDING TUBES Having a feeding tube does not eliminate the risk of aspiration. Stomach contents can still enter the airway via regurgitation or oral secretions can be aspirated if the person has dysphagia. Occasionally anti reflux surgery will be performed to tighten the lower esophageal sphincter. Having this surgery will not conclusively eliminate the risk of aspiration, but should lessen the risk. Some standard aspiration precautions are: • Administering tube feedings in an upright sitting position and keep upright for at least 45 minutes afterwards. • If the person must be fed in bed, keep the head of the bed at a 45 degree angle while feeding and for 45 minutes to an hour or as determined by the physician's order. • Don't overfill the stomach • Formula given at room temperature is better tolerated Don't feed too rapidly; feedings should be administered over at least 30 minutes or as ordered Difficulty in swallowing known as dysphagia can place a person at a higher risk for aspiration and complicate matters even more. Consulting a swallowing specialist such as the Speech and Language Pathologist (SLP) can develop a plan to reduce this risk. "Swallowing and Swallowing Disorders (Dysphagia), has long recognized and supported the need to improve the standardization of dysphagia diets based on evidence-based research. The following articles provide more information about the National Dysphagia Diet (NDD)..." (http://www.asha.org/Publications/leader/2003/031104/f031	

	104c/) The Speech Pathologist and Swallowing Studies http://www.eperc.mcw.edu/FileLibrary/User/jrehm/fastfactpdfs/Concept128.pdf Strategies for Improving Care for Patients with Advanced Dementia and Eating Problems: Optimizing Care Through Physician and Speech Pathologist Collaboration http://www.annalsoflongtermcare.com/content/strategies-improving-care-patients-with-advanced-dementia-and-eating-problems-full-title-bel **Constipation** Constipation is when a person has difficulty passing stool; the stools are hard, dry and often look like marbles. The frequency of bowel movements varies greatly from person to person. Bowel movements are considered normal as long as the feces are soft; normal sized and is passed easily out of the bowel. REVIEW OF HEALTH HISTORY FOR RISK OF CONSTIPATION • Has a current or previous diagnosis of constipation • Has a routine order for bowel medications and/or treatments • Use PRN bowel medications • Hospitalizations or outpatient treatments for constipation (bowel impaction, obstruction, or obstipation) • Takes medications that affect the body's hydration status or have constipating side effects • The person currently or in the past had a bowel protocol • Nursing documentation indicates that the person complains of stomach discomfort, strains with elimination, has abdominal distention, makes frequent trips to the bathroom or engages in rectal digging • Bowel record shows that the person is passing hard feces or bowel movements more than 2-3 days apart • Recent decrease or stopping of routine bowel	

	medications • Other personalized risk may be present **GUIDELINES ON HOW TO PREVENT OR MINIMIZE CONSTIPATION** • Encourage physical activity to increase muscle strength and tone • A positioning schedule for non-mobile people with time in an upright position. May need a physical therapist's consultation. • Review of medication for side effects of constipation • Establish toileting routines and schedule, for example (a) drinking a warm beverage first thing in the morning as ordered (b) teaching the person to take slow, deep breaths to increase abdominal pressure during toileting (c) teaching the person to respond to the natural urge to defecate, (d) placing feet on a small step stool while sitting on the toilet, € providing enough time and privacy for toileting • Observation of no bowel movement for more than three days or as determined by the physician will need to be reported. OBSERVATIONS THAT SHOULD PROMPT AN IMMEDIATE NURSING REVIEW • Abdomen firm to touch and/or looks distended and bloated • Complaints of stomach pain • Vomiting without any fever or flu-like symptoms and/or vomiting material that smells like fecal material (this is a medical emergency) • Runny liquid stools after days of passing small hard stools, small liquid stools or no bowel movements For more information on constipation and associated conditions please refer to the following link: http://www.niddk.nih.gov/health-information/health-topics/digestive-diseases/constipation/Documents/Constipation_508.pdf	

Dehydration
Dehydration occurs when a person does not drink enough fluids. Fluids are needed for temperature control, chemical balance and for cells to make energy and get rid of waste products. Dehydration occurs when the body loses more fluid then is replaced.

FACTORS THAT PLACE PEOPLE AT RISK FOR DEHYDRATION

- Unable to access fluids without assistance
- Needing assistance with drinking
- Dysphagia with coughing and choking during meals
- Food, fluid and saliva falling out of a person's mouth
- Frequently refusing food and fluids
- Suppression of thirst mechanism that results in the inability to recognize thirst
- Unable to effectively communicate thirst to nursing staff
- Medical conditions where fluid loss can potentially cause dehydration, such as kidney disease or diabetes
- Conditions where the person loses body fluids, such as drooling, diarrhea, sweating and vomiting
- Taking medications that affect body fluid balance, such as diuretics and lithium.

GUIDELINES FOR DEHYDRATION PREVENTION

- People should be encouraged to drink 8-10 glasses of fluid/day: persons who weigh more must drink more; persons who weigh less need less
- If a person is reluctant to drink fluids, offer foods high in fluid content such as gelatin, watermelon, puddings, yogurt or ice cream
- Persons who are very active, work hard, have a fever or perspire heavily need more fluids
- A person with dysphagia needs a swallowing evaluation by the SLP or other health care professional
- Implement a fluid intake and output protocol and provide training to all nursing staff providing care.

	Training should include; (a) having clear instructions regarding fluid requirements (b) listing acceptable minimal amount of fluid intake/day (c) consider the need and duration for monitoring intake and output (d) list of signs and symptoms of dehydration, what to do if seen and who to notify. For more information, please review the following articles on dehydration. ("Risk Factors and Outcomes Associated with Hospital Admission for Dehydration") http://www.rehabnurse.org/pdf/rnj293.pdf ("Water + Electrolytes: How They Prevent Dehydration") http://www.eletewater.com/uploads/elpdf/electrolytes and dehydration.pdf) Epileptic Seizures (follow guidelines for Seizure Disorder and Protocols-Standard 22)	