DDS

LIFE. YOUR WAY.
Department on
Disability Services

Developmental Disabilities Administration

Revised
Health and Wellness Standards

April 1, 2021

The original and subsequent Health and Wellness Standards were developed by the Department on Disability Services (DDS) in collaboration with the Georgetown University (GU) Center for Child and Human Development – University Center on Excellence in Developmental Disabilities Contract POJA-2005-R-RP05. These Revised Health and Wellness Standards involved GU's collaboration and feedback provided prior to August 31, 2019.

Acknowledgement

Acknowledgement of the State of Vermont
Division of Disability and Aging Services
for permitting use of the format used in the
Vermont Health and Wellness Guidelines (2004).

Appendix No.	***Appendices***	Where Find On-Line
1	Health Passport	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/HEALTH%20PASSPORT.PDF
2	Annual Preventive Health Screening Report (Male and Female), 2, 3	Female: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/female_form4_0.pdf Male: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/male_form4_0.pdf
3	Health Care Management Plan (HCMP) Template	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Health%20%20Care%20Management%20Plan%20Form%20.pdf
4	Development of the HCMP	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/HCMP%20Guidelines%20Feb%202015.pdf
5	Nursing Assessment Tool and Guidelines	https://dds.dc.gov/publication/nursing-assessment-form-and-guidelines
6	MRSA Brochure	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/MRSA%20Brochure_1.pdf
7	Self-Medication Assessment Tool	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/SAM-SelfAdminMedForm_0.pdf
8	A Checklist for Coordinators and Supervisors: Psychiatric and Behavioral Problems in People with Developmental Disabilities	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/A%20Checklist%20for%20Coordinators%20and%20Supervisors%20-%20Psychiatric%20and%20Behavioral%20Problems%20in%20Individuals%20with%20DD.pdf
9	Psychotropic Medication Review Form	https://dds.dc.gov/publication/psychotropic-medication-review-form
10	Transition of Care Guide	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Transition%20of%20Care%20Guide_1.pdf
11	DC Board of Nursing Delegation Tree	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Delegation%20Tree_0.pdf

12	“Thinking Ahead” – End-of-Life Planning	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Thinking%20Ahead%20-%20End%20of%20Life%20Planning_2.pdf
13	Protocol/Worksheet for Refusal of Treatment of Services	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Protocol%20for%20Refusal.pdf
14	Adaptive Equipment Medicaid Process Flow New Equipment	https://dds.dc.gov/node/734252
15	Adaptive Equipment Medicare Process Flow Repair to Equipment	https://dds.dc.gov/node/1452951
16	Down Syndrome Health Care Guidelines	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Adult%20Down%20Syndrom%20Health%20Care%20Guidelines%20%281%29.pdf
17	Adult Seizure Record Form & Seizure Tracker Log Form	https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/adult_seiz_record.pdf
18	Annual Psychiatric Evaluation Form	https://dds.dc.gov/node/1447151
19	Glasgow Depression Scale Questionnaire	https://dds.dc.gov/node/1452961
20	GU Trauma Exposure & Symptom Record	https://dds.dc.gov/node/1464066
21	GU Trauma Informed Care Public Health Model for Developmental Disability Services	https://dds.dc.gov/node/1464071
22	Health List	https://dds.dc.gov/node/1466426
23	GU Dementia Differential Diagnosis Checklist	https://dds.dc.gov/node/1464096
24	Sexual Health and Intimacy Questionnaire	https://dds.dc.gov/node/1466431

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 Department on Disabilities Services (DDS), 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 IDD waiver) or, the person lives in an Intermediate Care Facility for People with Intellectual and Developmental Disabilities (ICF/IDD). 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;
- Maintenance of 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.

Documentation:
Any variance in health and wellness services must be documented in the health record.

Variances: Variances to the *Health and Wellness Standards* must be documented by an involved medical or nursing professional. ***Applies to:*** People residing in an ICF/IDD. People enrolled in the HCBS IDD waiver who receive residential habilitation, supported living, or host home supports.	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; 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 an informed choice. Refusal from medical appointments/treatments: • A refusal form must be filled out for each refusal of a medical appointment or treatment. o Refusal of Treatment or Services protocol should be initiated and a plan put into place. • A subsequent refusal of the same medical appointment or treatment needs to be discussed with the primary care physician (PCP)/Nurse Practitioner (NP) as to the necessity or alternatives. • If a person continues to refuse medical related services and alternatives that are needed to help maintain their health and safety at the home, the provider team, PCP, person/family and service coordinator should meet to evaluate interventions that have been implemented and develop a plan of action up to and including discharge, if necessary. • Refusal of medication administration • A refusal of medication administration should be documented on the medication administrative review (MAR) and an incident report written. • A note from the nurse in the progress notes should be entered indicating risks/benefits were discussed.	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.

- Daily refusal of a medication in one week should be referred to the ordering physician or NP for alternatives or discontinuation.

Refusal of other services

- Refer to the Guidelines for Implementation of Refusal of Treatment or Services available at https://dds.dc.gov/page/guidelines-implementation-refusal-treatment-or-services.

Examples of situations where a variance might be indicated include:

- 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.

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 available to all those involved in supporting the person. ***Applies to:*** ***Required for:*** People residing in an ICF/IDD. People enrolled in the HCBS IDD waiver who receive residential habilitation, supported living, or host home supports. Quarterly updates are required in ICF settings and annually in HCBS IDD 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.	**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. It is available at: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/HEALTH%20PASSPORT.PDF (Appendix 1). 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 (qualified intellectual disabilities professional (QIDP) and RN) • DDA service coordinator • Healthcare providers (PCP, dentist, psychiatrist, psychologist, and medical specialists such as cardiologists, neurologists, gynecologists, 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 style(s). For example, does the	***Documentation:*** A copy of the current *Health Passport* will be maintained at a person's residence. It is required that a current paper or electronic copy of the *Health Passport* accompany a person to day and/or vocational services, and to all medical appointments. Use the medical problem section to document only past, current and recurrent medical history.

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, self-feeding ability
- 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 (active) medical and mental health diagnoses. This includes diagnoses which may be temporary (currently active), such as a urinary tract infection, Methicillin Resistant Staph Aureas (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

In the immunization record section, nurses should indicate the type of immunization, date and lot number, if available.

7. Medication Information

Medication names, start dates, dosages, times, routes, reason for medication and discontinuation dates

All 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.	

Standard 1a ***Health List:*** 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 available to all those involved in supporting the person. ***Applies to:*** ***Required for:*** People who live independently or in natural homes who receive high acuity services. ***Recommended for:*** The Health List is recommended for people living independently or in a family home. The Health List document will be introduced to the person and family member during intake, at the ISP, or by the provider nurse for those receive high acuity in-home supports.	**Health List** For people living independently or in natural homes, the *Health List* is required for those receiving High Acuity In Home Supports (See Standard 27). For persons not in this category, a Health List that includes a list of current medical diagnosis, current medications with dosages and allergies can be initiated with the day/ vocational services provider, during the ISP, or during intake, and be maintained by the person, family, guardian, or substitute decision maker. It is the service coordinator's responsibility to educate the person and/or his/her healthcare decision-maker about the benefits of the *Health List.* Once initiated, the Health List should be reviewed at least yearly during the ISP meeting. If the person is attending a day program then the form should be reviewed bi-annually. **Source***:* Health List available at https://dds.dc.gov/node/1466426 (Appendix 22).	***Documentation:*** A copy of the current *Health List* will be maintained at a person's residence. It is expected that a current paper or electronic copy of the *Health Passport* accompany a person to day and/or vocational services, and to all medical appointments. Use the medical problem section to document only past, current and recurrent medical history. A discontinued medication list should be maintained in the medical record.

Standard 2	**Coordination of Health Care Services**	***Documentation:***
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:*** People residing in an ICF/IDD. People enrolled in the HCBS IDD waiver who receive residential habilitation, supported living, or host home supports. Quarterly updates are required in ICF settings and annually in waiver settings.	Coordination of health care services is the responsibility of the residential service provider. This responsibility will be directed by an 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 the ability to interact with community agencies (See Board of Nursing Delegation Tree, available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Delegation%20Tree_0.pdf (Appendix 11). Care coordination also includes contacting consultants for any referrals in a timely manner for all recommended assessments, securing copies of the consultants' assessments (physical therapist (PT), occupational therapist (OT), or speech-language pathologist (SLP), and ensuring that they are maintained in the record. Assessments must be current and uploaded into MCIS within 72 hours of the provider receiving the consult's assessment. It is expected that the nurse responsible for taking medical orders for pharmacy purposes should modify the *Health Passport*. For new health problems, the diagnoses should be confirmed with the PCP or NP. All updates should be made within 7 days. For people who do not receive nursing services, such as those in natural home settings, the day/vocational service providers or family can assist with the person and their support team to modify the *Health List*. **Transition from Hospitalization/ Facility (LTC) or Long-Term Acute Care Facility (LTAC)** The transition from hospital/nursing home 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 and implementing consistent processes can reduce such risks. • Hospital/LTC/LTAC discharge planning meetings must be attended by the community-based provider nurse. • Upon returning home, head-to-toe nursing assessment, vital signs, and a focused note	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. After discharge, the instructions should be uploaded in MCIS within 48 hours for nurse to review prior discharge follow up home visit. The nurse should properly document all concerns in the consultation sheet during medical appointments with all labs/ supporting notes or log and instruct the staff to have the PCP sign all pending verbal orders within 30 days. For example, if the Lab revealed a low HCT/HGB value, this must be addressed by the PCP and captured in progress notes.

	documented in the progress notes must be completed within 24 hours. • If there are any significant changes, the Health and Safety Assessment must be revised within 7 days. • Notification via email to the H&W nurse and upload of discharge instructions in the reported incident under the documentation tab must be completed within 48 hours of discharge. • Post-hospitalization follow-up visit must be attended by the community-based provider nurse, QIDP or House Manager. (It is recommended that this visit include a review of medications, diagnostic tests, consults, diet, and activity.) *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* is available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Transition%20of%20Care%20Guide_1.pdf *(*Appendix 10*)*.	

Standard 3	**Preventative Health Care**	***Documentation:***
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/IDD. People enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services. ***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 completed annually and recorded on the Annual Preventive Health Screening Report. If a person requires a variance from the USPSTF recommended screenings, its rationale must be documented in the record by a PCP/NP in the progress notes. Health Form 2 and Health Form 3 are useful forms for reviewing the person's medical history and for ensuring the person receives quality care. *Annual Preventive Health Screening Report (male & female), Fall Assessment, Health Form 2, and 3* are available at: Female: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/female_form4_0.pdf Male: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/male_form4_0.pdf. (Note: Together, the Female and Male forms are Appendix 2.) 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 cannot self-report and the RN would need to complete. 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 (RN) to seek a referral for mental health consultation or from a psychologist (if the person resides in an ICF/IDD	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 annual preventive screening sections should be addressed with a note "not indicated based on screening indicators" in the event the screening is not applicable. The Glasgow, fall assessment, dementia, Braden, etc. are done annually at the time of the ISP. All nursing protocols should be updated annually and dated. Staff should maintain all protocols in the current medical record. Seizure logs should be maintained and documented for people with an active diagnosis and current seizure activity.

	setting). The Glasgow Depression Scale does NOT need to be given to persons that are already receiving treatment for a clinical diagnosis of depression. Glasgow Depression Scale Questionnaire, available at https://dds.dc.gov/node/1452961 (Appendix 19).	

Standard 4 ***<u>Support during Declining Health</u>:*** All people will receive support from healthcare providers, residential support staff, DDA service coordinators and H&W nurses to ensure that changes in health care needs are adequately addressed. ***<u>Applies to:</u>*** ***Required for:*** People residing in ICFs/IDD. People enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services. ***Recommended for:*** People living independently or in a family home.	**People Experiencing Declining Health** Staff members who support a person must be familiar with that person's baseline level of functioning with respect to both health and behavior. If a staff member observes changes in a person's baseline, they must report their observations to the nurse, PCP/NP, or relevant healthcare professional. Depending on the level of supports received and by whom, the residential staff or nursing personnel, will be responsible for ensuring that all changes are thoroughly documented to assist the PCP/NP and/or medical specialists in the diagnosis, treatment and evaluation of the health situation. The provider nurse working in collaboration with the person, health care decision-makers, health care decision supporters, guardian (if named), residential agency staff, and service coordinator will ensure that: • The PCP/NP conducts a timely and adequate medical evaluation to identify the etiology of the problem(s); • The PCP/NP 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. For Natural Homes: The service coordinator and/or Health and Wellness nurse working in collaboration with the person, health care decision-makers, health care decision supporters, guardian (if named), and residential agency staff will ensure that: • The PCP/NP conducts a timely and adequate medical evaluation to identify the etiology of the problem(s); • The PCP/NP 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/NP 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).	***<u>Documentation</u>*** For people experiencing a decline in health, a comprehensive plan of care must be documented by the PCP/NP and/or residential support RN in the health record progress notes. Deferral or decline of any health recommendation made by the PCP/NP or specialists must be thoroughly documented in the health record progress notes. For those in Natural Homes a note can be placed in MCIS denoting any follow-up care that has occurred.

	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 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 Standard 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; or • 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 IDD waiver plan of care.

Screening for and Managing Dementia

Dementia is a growing concern for people with intellectual disabilities because they are reaching older age, which is a risk factor for the development of dementia, and people with Down syndrome are at such an increased risk of developing Alzheimer's-type dementia.

The Annual Preventive Health Screening Report (Health and Wellness Standard 3: Preventive Health Care) directs the use of the National Task Group on Dementia and ID Early Detection Screen for Dementia (NTG-EDSD) on all people with Down syndrome on an annual basis once they reach 40 years of age, and for all other people if cognitive changes are seen at any age. If changes are noted, an interdisciplinary process is needed to ensure that the proper process for the differential diagnosis of dementia has taken place, since dementia itself is a symptom that can have a number of etiologies.

The *GU Dementia Differential Diagnosis Checklist*, available at https://dds.dc.gov/node/1464096 (Appendix 23) should be used to assist in guiding best practice in the conduct of a differential diagnostic process and to document the process that was completed to provide an accurate account for the medical record.

The *Dementia Differential Diagnosis Checklist* is divided into three sections. The first section notes the date of the NTG-EDSD, as well as recording when the results have been reviewed by the clinical staff, and schedules for follow up visits with the primary care practitioner and any specialists.

Some important considerations for Section I of the *Dementia Differential Diagnosis Checklist*:

- The diagnosis of dementia may need to occur over time, until certain conditions are ruled out or the person' deterioration has progressed. You may not have sufficient positive findings on the first screen, but the screening may need to be repeated at 6 or 12-month intervals.
- Document in the progress notes other professionals with whom you have reviewed the screening results.

	• Revisions to the HCMP and the ISP may be needed based on the results of the Checklist. • Document referrals to the primary care provider and any recommendations from that referral. Section II of the *Dementia Differential Diagnosis Checklist* is a guide for the physician to ensure that disorders that may cause dementia and mimic Alzheimer's disease have been ruled out such as certain medications, nutritional deficiencies, thyroid abnormality, depression, spinal cord abnormalities and sensory deficits. Some important considerations for Section II: • The PCP should review the list of current medications for those that have the potential to mimic dementia. If the person is seen by a psychiatrist, they should also review the list of prescribed medications. Ensure that this review is documented in the medical record. • Referral to audiology and/or ophthalmology should only be done after a positive screen. • Spinal cord abnormality may manifest itself in changes in ambulation. • Section III of the *Dementia Differential Diagnosis Checklist* includes space for the actions taken by either a neurologist or psychiatrist, or if a second opinion is obtained. This section also documents that key informants have been interviewed and any advanced testing recommended by the PCP or specialist. Once all of the information has been collected: • The PCP or specialist should make a report of the findings. • If the findings are inconclusive, a plan should be in place for the continuation of follow up. • If a dementia diagnosis is made, an ISP meeting should be convened for the purpose of identifying any changes in support services that may be required. • The HCMP should be modified as necessary, and all staff trained in order to provide a dementia-capable environment for the person. (See DDA Health Initiative web page for additional resources in this area). This record should be a permanent part of the person's medical record, including if a transfer occurs to another service agency.	

Standard 5	**Health Care Management Plan**	***<u>Documentation:</u>***
Health Care Management Plan (HCMP): Anyone receiving nursing services via the HCBS IDD waiver or who lives in an ICF/IDD should have a HCMP developed. ***Required for:*** Anyone enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services, or anyone who lives in an ICF/IDD. 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. **See Standard 27 for anyone living in a natural home setting**	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 by the RN and reviewed during the annual ISP process and is attached as an addendum to the ISP. ICF: HCMP is initiated and developed by a RN during the admission of the person to the agency, quarterly, annually, and/or when changes occur. Residential habilitation/supported living/Host Home: HCMP is initiated and developed by an RN during admission of the person to the agency, annually, and/or when changes occur. HCMP must be review/updated whenever a nursing assessment is updated due to hospitalization, new nurse transition, or transition to another provider. The initial HCMPs should be uploaded into MCIS under the person's profile in the Residential tab by the residential provider and any modifications should be uploaded within 7 days. The HCMP is used to guide the implementation of all healthcare activities across multiple settings and must be attached as supporting documentation with 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	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. The HCMP should address unresolved health issues, including diagnoses that are being treated and monitored. It should include measurable goals and interventions. All specific protocols should be signed/dated and revised annually. Health and Safety Nursing Assessment should be signed/dated and revised at least annually. After any discharge, the instructions should be uploaded in the MCIS within 48 hours for nurse to review prior to

	- Health and Safety Nursing Assessment – The RN must use the designated DDS nursing assessment form or a comparable electronic nursing assessment form approved by DDS. A new HCMP shall be developed annually by the RN 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 RN, in ICF/IDD 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 (e.g., post-hospitalizations, new diagnosis that change the level of care, etc.), the HCMP should be updated immediately. For new admissions to the agency, the HCMP must be completed by the RN within 15 days of admission. The RN'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 RN 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. **Nursing Assessment** The nursing assessment is a key component of nursing practice, required for planning and provision of person-centered care. The RN 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	home visit follow up.

	nursing assessment tool is ideal to be utilized in both the ICF and HCBS IDD waiver settings. The nursing assessment tool is described below to support the development of the HCMP. Alternatively, providers who are using an electronic medical health record, it should be an approved electronic nursing assessment form. Send a request for review of the format to DDS's Supervisory Community Health Nurse. *The Health and Safety Assessment* is to be utilized by a RN in assessing adults with 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 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, available at https://dds.dc.gov/publication/nursing-assessment-form-and-guidelines (Appendix 5). A nursing assessment should be completed as part of the initial ISP 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. **Desired Outcomes** The HCMP includes the identification of Desired Outcomes." It is important to identify desired 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.	These desired outcomes must be objective, meaning measurable, to document progress and justify that the

	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; • The plan should be revised if outcomes are not being met; and • Promotes accountability. Desired outcomes: • Focus on the person and are a part of person-centered thinking; • Consist of clear and concise statements; • Are measurable; • Are time-limited; • Present realistic goals; and • Represent a mutual decision between the nurse, the person and any health care decision-maker. **Role of the Qualified Intellectual Disabilities Professional** The QIDP qualifications are subject to state interpretations required under federal ICF/IDD regulations as members of the interdisciplinary team. QIDPs and the function performed by personnel serving in 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 QIDP 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 RNs are part of the support team, the QIDP and the RN must work collaboratively. While the RN is responsible for the development of the HCMP [see Standard 5], the QIDP must be knowledgeable of all aspects of the plan. The skills of the QIDP are essential in attaining the	treatment is medically necessary. Desired outcomes should be person-specific and focus on skills that the person wants to improve. Set short term goals with a time frame for each skill area.

desired outcomes articulated within the HCMP. They do this through:

- Facilitating and keep record of all trainings to ensure 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.
- Monitoring that DSPs are competent in the use of the equipment
- Ensuring, in collaboration with the nurse, that all appointments with primary, specialty and auxiliary health care providers are made/kept, including adequate transportation and staff support during the appointment.
- Observe and report any interferences in the person's ability to engage in employment and other community activities.

It is recommended that when the QIDP documents the execution of their responsibilities, they adhere to the following guidelines:

1. Use the desired outcomes of the HCMP as a guide to monitor, facilitate, and report on the implementation of the DSP interventions.
2. QIDPs are required to review the HCMP quarterly in both ICF and waiver settings and place a note in MCIS.
3. Avoid charting identical information as the RN. Instead, document the specific functions of the QIDP (i.e., facilitate and keep record of training for DSPs on HCMP interventions, acquisition and maintenance of adaptive equipment, medical appointments, observe and report any interference on the person's ability to engage in employment and other day and community activities).

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 Code of Ethics (http://www.directsupportprofessional.org/docs/NADSP_Code_of_Ethics.pdf) 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 (EMS). 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 HCMP. Signs and Symptoms DSPs need to be trained on the elements of *Stop and Watch* and reporting protocols for the person 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 3 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:

- Diet restrictions related to diabetic, low sodium, fluid restricted or calorie restricted diets.
- Recognition of high or low glucose and emergency procedures for people with insulin-dependent diabetes.
- Food, environmental, seasonal or drug allergies.
- Seizure recognition and first aid.
- Existence of mealtime, positioning and behavioral support plans and protocols.
- Use of adaptive equipment including internal devices such as pacemakers, baclofen pumps and shunts.
- When to activate the Emergency Response System (911) and when to initiate cardio-pulmonary resuscitation (CPR) and the Heimlich maneuver.

Standard 6 ***<u>Medical Consent:</u>*** Consent from the person or his/her authorized 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, his or her authorized health care supporters, and his/her authorized healthcare decision maker is also informed of any changes in health status. ***<u>Applies to</u>:*** People who live in an ICF/IDD. People enrolled in a HCBS IDD 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 in this context is the ability, with or without support, to appreciate the nature and implications (risks and benefits) of a health care decision, to make a choice regarding alternatives presented, and to communicate that choice in a clear manner. It is important that a person’s capacity to make medical decisions not be clinically assessed without allowing the person the opportunity to consult with or receive support from others of his or her choosing. Many people with intellectual and developmental disabilities can provide medical consent using Supported Decision-Making. *Supported Decision-Making (SDM)* is when a person with a disability makes his or her own decisions by using friends, family members, and other people he or she trusts to help understand the issues and choices, ask questions, receive explanations in language he or she understands, and communicate his or her own decisions to others. A *Supported Decision-Making Agreement (SDMA)* is a way to put an SDM relationship in writing and can cover health care decisions. Such agreements do not allow a named supporter to make the decision for the person. Rather, the person remains the decision-maker. In the medical context, SDM also can be facilitated using *Health Insurance and Portability Accountability Act (HIPPA) release of information forms*, which allow a person to give written permission for health care providers to share personal health information with others. People who are unable to give consent, even with support, may have an authorized healthcare decision maker, which could include: • An agent identified in a power of attorney for health care or • A substitute healthcare decision maker. <u>*Power of Attorney*</u>: A legal document that a person knowingly and voluntarily signs that authorizes someone (an “agent”) he or she trusts to act for him in certain circumstances.	***<u>Documentation:</u>*** Copies of medical consent forms, any durable powers of attorney for health care, any SDMAs covering health care, and any medical release of information forms must be maintained in the Health Record.

A *Substitute Healthcare Decision Maker* is anyone authorized by law to make healthcare decisions for a person who cannot make those decisions himself or herself, even with support, and who does not have a power of attorney. In D.C., if a person does not have a guardian, a person can only have a substitute healthcare decision maker if two qualifying professionals have certified in writing that he or she does not have the mental capacity to make a healthcare decision. A substitute healthcare decision maker may be, for example, a court appointed temporary or permanent guardian who the judge has, by court order, given authority to make the decision. Sometimes a substitute health care decision-maker is a family member who has not gone to court to become the legal guardian, but who is still authorized to make health care decisions for the person by operation of law; these are called “21-2210 Medical Decision-Makers.”

A substitute healthcare decision maker’s decision about healthcare should be guided by a “substituted judgment” standard – i.e., 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.

Supporters, agents under powers of attorney and substitute healthcare decision makers are an important part of a person’s support team. However, they do not replace the person, who should continue to be involved in the medical decision-making process if he or she wants to be, encouraged to share his or her wishes with the support team, and supported to build decision-making skills over time.

General Guidelines Related to Medical Consent

Less restrictive healthcare decision-making support options like SDM and Powers of Attorney should be fully explored and exhausted before resorting to more restrictive ones, such as Substitute Healthcare Decision-Makers. Whenever possible, all medical information should be explained to the person in a way that he or she understands. The authorized healthcare decision maker (if there is one) 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 authorized healthcare decision maker (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, his/her authorized health care supporter(s), and his/her authorized healthcare decision maker/guardian (if there is one) during the consent process: • The symptoms targeted by the medication. • The physician/NP’s explanation of the expected benefits of the medication and the alternatives available. • Information about how side effects will be monitored and minimized. • A plan to track or monitor medications and their effects must be implemented. • The physician/NP’s explanation of the risks associated with the proposed medications such as contraindications for certain health conditions, drug interactions, dosages outside the usual range, black box warnings, and off label use. Information about the risks must be documented on the medical consult form and maintained in the health record. • A rationale for recommending the use of the medication when risks are present. • Information about when reduction or discontinuation of medication will be appropriate. 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 RN shall inform the person, his or her authorized health care supporter(s), and the authorized health care decision-maker (if there is one), and the service coordinator when tests are ordered, especially if a problem is suspected, and the outcome.	

Standard 7	**Reporting Critical Incidents**	***Documentation***
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 the 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. Please refer to Incident Management Enforcement Policy and Procedures. It is essential for providers to implement and maintain an incident management system and report critical incidents to DDA. Source: *DDS's Incident Management and Enforcement Policy and Procedures,* available at https://dds.dc.gov/page/policies-and-procedures-dda.	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.

Standard 8 ***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.	**Behavioral Support Plan** 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. The RN 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 HCMP. For example, target behaviors identified in the BSP should be part of the expected outcomes for the person. 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. 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. Please refer to the BSP Policy at https://dds.dc.gov/node/738712 and Procedure at https://dds.dc.gov/publication/bsp-requirements-procedure.	***Documentation*** Documentation of a functional assessment of behavior, and the BSP, will be maintained in a separate section of the Health Record. Per DDS's policy, a copy will be maintained in an easy to access record for staff to refer to the plan as needed. All BSPs that include a restrictive component must be reviewed and approved by the Restricted Control Review Committee (RCRC).

Standard 9	**Restrictive Procedures**	***Documentation:***
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 BSP. ***Applies to:*** All people receiving supports through DDA.	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 people in the community or privacy. 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. Please refer to the Restrictive Controls Review Committee (RCRC) Procedures at: https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/RCRC%20Procedure%208-9-2013_0.pdf and the Human Rights and Advisory Committee Policy and Procedures and Definitions at: https://dds.dc.gov/page/human-rights-advisory-committee.	Documentation of the approval of the use of restrictive procedures by the agency's human rights committee will be maintained in the Health Record.

Standard 10

Universal Precautions/ Bloodborne Pathogens Training:
It is a federal requirement that Bloodborne Pathogens training be presented to employees with the potential for occupational exposure. This training must be provided in accordance with the OSHA requirements. 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 Pathogens Training

"Universal precautions," as defined by Centers for Disease Control (CDC), are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), Hepatitis B virus (HBV), and other bloodborne 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 bloodborne pathogens.

The term, *bloodborne 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, HBV and HIV.

All agencies must comply with Occupational, Safety, and Health Administration (OSHA) requirements related to blood borne pathogens and universal precautions.

According to OSHA Regulation 29 CFR § 1910.1030, all employer agencies must:

- Provide an initial Bloodborne Pathogens 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; and
- 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 exposures.

Documentation:
Documentation of Bloodborne Pathogens training sessions will be maintained in agency training records.

A copy of the agency's Exposure Control Plan must be available to all employees.

	Source: OSHA Regulation, 29 CFR § 1910.1030 available at https://www.osha.gov/SLTC/bloodbornepathogens/	

Standard 11	**Management of Infections**	***Documentation:***
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 HCBS IDD waiver receiving residential habilitation,	Antibiotic resistant bacteria such as MRSAs, Vancomycin Resistant Enterococci (VRE), and Klebsiella are the most commonly encountered drug-resistant infections in people residing in community settings. 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: • Colonization, where the organism is present, but not causing illness, or • Infection, where 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: • Handwashing with soap and water after physical contact with the colonized or infected person; • Towels used for drying hands should only be used once; • Disposable gloves should be worn if contact with blood and/or 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; and • Instruct people to observe good hygiene practices.	Information related to management and individual response to treatment will be documented on the HCMP and in the nursing and physician progress notes.

supported living, and host home services.	People with colonized and/ or infected MRSA/ VRE should be encouraged to participate in their usual social, and therapeutic activates. However, if draining wounds are present, they should be covered. *Source: CDC (2018)* available at https://www.cdc.gov/mrsa/index.html. *For additional information on MRSA, see brochure,* available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/MRSA%20Brochure_1.pdf (Appendix 6). **Klebsiella** Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. Increasingly, Klebsiella bacteria have developed antimicrobial resistance, most recently to the class of antibiotics known as carbapenems. Klebsiella bacteria are normally found in the human intestines (where they do not cause disease). They are also found in human stool (feces). In healthcare settings, Klebsiella infections commonly occur among sick patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators (breathing machines) or intravenous (vein) catheters, and patients who are taking long courses of certain antibiotics are most at risk for Klebsiella infections. Healthy people usually do not get Klebsiella infections. To prevent the spread of infections, persons also should clean their hands very often, including: • Before preparing or eating food; • Before touching their eyes, nose, or mouth; • Before and after changing wound dressings or bandages; • After using the restroom; • After blowing their nose, coughing, or sneezing; and • After touching surfaces such as doorknobs, remote controls, or the phone; *Source: CDC (2018)* available at https://www.cdc.gov/HAI/organisms/klebsiella/klebsiella.html.	

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, perforation 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 (2018) available at https://www.cdc.gov/cdiff/index.html.

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 needle sticks 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 (2018*) available at https://npin.cdc.gov/pages/viral-hepatitis-guidelines-and-recommendations.	

Standard 12	**Annual Physical Exam**	***Documentation:***
Annual Physical Exam: Annual physical exams are required for all people receiving supports and services from DDA, unless otherwise documented, in writing, by the PCP. ***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, NP or physician's assistant. Annually, the PCP 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. The DDS Medical Evaluation Form is available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Medical%20Evaluation%20Form.pdf The residential provider shall ensure that all consultations with specialists will 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 PCP or NP. The PCP or NP should, in turn, document in writing they have reviewed the consults and any recommended follow-up treatment. Any decision to decline a recommendation should also be documented including rationale. The residential provider shall ensure that all laboratory and procedural reports will 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; and • Recommendations.	Documentation of comprehensive health services including health assessments, DDS-required laboratory tests (CMP, CBC, Lipid panel, Hgb A1C, RPR, VDRL, UA), diagnostic, and screening tests, and specialty consultations will be maintained in the health record.

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.

The assessment should include the:

1. Physician's name, signature and date;
2. Complete medical problems list;
3. Body systems review with vital signs, measured weight, and ideal body weight;
4. Complete list of prescribed medications, including over-the-counter medication and any other alternative therapy used by the person;
5. A list of laboratory, diagnostic or preventative screening tests in compliance with the US Preventative Health Task Force (See Annual Preventive Health Screening Report); and
6. Any recommendations made by the PCP.

The service coordinator in consultation with Health and Wellness will provide a list of medical providers for those who reside in their natural homes or independent living and do not have a PCP.

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.
- Bring current Annual Preventive Health Screening Report 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 x-rays 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.	**Oral Health & Hygiene** Persons' dental needs should be addressed by their primary dentist. 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, education on how to properly take care of denture; to prevent cracking, breaking, etc. 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. Education on importance of brushing and flossing the teeth daily to potentially prevent tooth decay and cavities.	***Documentation:*** Documentation of dental care and specialty consultations will be maintained in the health record of the residential provider.

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** The current hearing assessment results should be provided by the audiologist and maintained in the medical record. 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. 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. https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Adaptive%20Equipment%20Maintenace%20Protocols.pdf.	***Documentation:*** Documentation of hearing screenings and audiological recommendations will be maintained in the health record of the residential provider.

Standard 15 ***<u>Vision/Eye Health Care:</u>*** People should receive vision screening if a problem is detected through observation of their interaction with their environment. People with Down syndrome require exams every 2 years. ***<u>Applies to:</u>*** People who are living in an ICF/IDD. People enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services.	**Vision/Eye Health Care** The U.S. Preventive Services Task Force does not recommend screening during the annual primary care visit, except for 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 as determined by the PCP/NP. Additionally, 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 are concerns about a person's vision, they need to be referred to an Ophthalmologist for an evaluation. A baseline ophthalmology evaluation recommendation should be requested from the PCP due to the number of persons with developmental and intellectual disabilities who tend to develop visual disturbances including Glaucoma, Myopia, Astigmatism, and Cataracts. If someone is prescribed eyeglasses, please refer to the Adaptive Equipment Manual for suggestions for proper maintenance.	***<u>Documentation:</u>*** Documentation of eye health is part of the annual nursing assessment and progress notes for any acute event.

Standard 16	**Immunizations**	***Documentation:***
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 HCBS IDD waiver receiving residential habilitation, supported living, and host home services.	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. Day programs should develop health promotion strategy(s) that encourages persons to receive the annual influenza (flu) vaccine and PPD screening, as recommended by the CDC. The Adult Immunization Schedule Recommendations are available at http://www.cdc.gov/vaccines/schedules/hcp/adult.html, and are incorporated by reference. A suggested format for documenting the vaccination record is available at http://www.immunize.org/catg.d/p2023.pdf. Source: *CDC Adult Immunization Schedules.*	Immunization documentation will be maintained on an immunization record form as part of the *Health Passport.* Flu vaccination may be maintained on the Health List of people who live in natural homes.

Standard 17	**Medication Prescription and Administration**	***Documentation***
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/IDD. People enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services.	**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 of the prescribing physician or NP, frequency 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 prescribing physician or NP. 4. Only a licensed nurse (RN or licensed practical nurse (LPN)) shall accept a telephone medication orders from a licensed physician/NP for a new prescription or change in dosage or frequency. 5. PRN (as needed) medications are medications that are ordered by the prescribing physician /NP to be administered on an "as needed" basis according to specific written parameters by the physician/NP. Parameters must include the necessity for administration, the time/frequency/conditions, if any, 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 prescribing physician/NP. The pharmacist should be informed of any over-the-counter medications because they may interact with prescription medications.	Medication administration will be documented in the MAR for people who live in an ICF/IDD or with HCBS residential providers. All documents in the person's medical record must be dated and signed. The TME observation scorecard must be available during review. The nurse must administer all initial medications. The provider nurse should sign the front of the MAR at the beginning of the month and sign the back to represent review and oversight of the process at the end of the month.

	7. All medications and dosages must be checked by the nurse (RN/LPN) for accuracy at the time of purchase and/or delivery. 8. The supervisory RN, 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/NP time, dosage, method of administration, and duration 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 MAR and the *Health Passport*. **Medication Administration** 1. All medications must be administered as ordered. The first dose of any new medication should be administered by the provider RN. MARs are required for all waiver 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 an incident report and reported to the RN who will report it to the PCP/NP. 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 observations, verbal or telephone approval by a RN nurse prior to its	

administration by a Trained Medication Employee (TME).

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, MARs, 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 RN 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*

The residential provider's RN can consult with DDS's Health and Wellness nurses if assistance is needed for self-medication assessment.

For information on self-medication, see Self-Medication Assessment Tool, available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/SAM-SelfAdminMedForm_0.pdf (Appendix 7).

Direct care staff should notify the RN if they have concerns about the person's ability to self-administer medications.

Training and Monitoring

TMEs are people 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 RN on an ongoing basis. The supervisory RN shall be available to the TME for general or direct supervision. 2. Prior to administering medication to a program participant, all TMEs shall: • Observe a RN administering medication on at least two (2) occasions • Be observed by a RN as required by Board of Nursing. • Demonstrate proficiency and knowledge for all program policies pertaining to medications • Demonstrate knowledge of medications to be administered 3. A RN 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 RN. 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 RN is responsible for ongoing monitoring of all people who administer medications to ensure 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.*	

Standard 18 ***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 psychotropic 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** Psychotropic medications are medications that affect or alter thought processes, mood, sleep, or behavior. Psychotropic medications are prescribed for specific dysfunction in thinking, feeling, and behaviors caused by a diagnosed psychiatric illness in order to improve quality of life for affected people. Psychotropic medications when used should strive to find a minimal effective dose (MED) and be part of an overall treatment strategy that includes psychosocial treatment interventions. These interventions include the identification and management of stressors, person-centered thinking strategies, changes needed in the environment, trauma-informed supports, teaching people and caregivers, and other treatment approaches such as cognitive-behavioral therapy. DDS has adopted the following standards: • A licensed, board-certified psychiatrist or NP must make all decisions: a) if a person should undergo a formal assessment for a mental health 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. • The use of psychotropic medications on a PRN basis is expressly prohibited by DDS's Behavior Support Policy • Psychotropic medication shall only be prescribed to people with intellectual and developmental disabilities that have a formal psychiatric assessment and a diagnosed mental health disorder. • Documentation from the psychiatric provider will be required acknowledging the mental health diagnosis and, if clinically justified, psychiatric assessment recommendations for psychotropic medication use for the person. • The medication consent process should explain to the person (or the person's substitute healthcare decision maker): o The symptoms targeted by the medication; o The benefits of the medication; o Specific risks associated with the proposed medications such as contraindications for certain health conditions, drug interactions, dosages outside	***Documentation:*** The Psychotropic Medication Review Form will be used to document the interdisciplinary review of prescriptions for psychotropic medications.

    the usual range, black box warnings, and off label use; and
    - Information about when reduction or discontinuation of medication will be appropriate.
- The psychiatric treatment plan must be incorporated into the ISP, and a behavior support plan or BSP exemption will be in place following the prescription of the medication(s) in accordance with the DDS's BSP Policy.
- Physician's orders, including those for psychotropic medication and sedation, require informed consent prior to initiation and must be implemented as ordered and without delay to ensure people's health and safety.
- If a person with an intellectual disability is prescribed psychotropic medication during an emergency room visit for a behavioral crisis, then a psychiatric assessment conducted after the immediate crisis is resolved, is required to determine whether a diagnosed mental health disorder is present and determine whether psychotropic medication continues to be necessary.

Intellectual Disability and Autism Spectrum Disorder (autism) are excluded from the definition of mental health disorders in the District of Columbia. Therefore, the use of psychotropic medication for people with intellectual disabilities or autism is prohibited by the DDS's Behavior Support Policy unless the person also has a diagnosed mental health disorder. If a person with an intellectual disability or autism is prescribed psychotropic medication without a formal psychiatric assessment and diagnosed mental health disorder, implementation of the physician's order for psychotropic medication should continue without disruption while working with the person's psychiatrist to come into compliance with the DDS's Behavior Support Policy.

- For BSPs that have been written for people who are taking psychotropic medication and currently only have a diagnosis of autism, full approval of these BSPs by DDS's RCRC will be deferred until the BSP is revised to indicate a co-occurring mental health disorder in addition to autism.

- The concept of 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:

  - Any person not currently taking a psychotropic medication with tardive dyskinesia (TD) as a side effect shall receive a baseline screening under the following circumstances:
    - Upon recommendation for treatment with psychotropic medications with TD as a side effect, 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 previously taking psychotropic medications with TD as a side effect.
  - All people currently taking psychotropic medications with TD as a side effect shall be assessed at least semiannually or more frequently as necessary by symptom assessment or determined by the prescribing practitioner.
  - Any person currently taking psychotropic medications with TD as a side effect who is newly admitted to a DDS-operated, funded, or licensed facility shall have an initial screening within one month of admission.
  - Any person whose psychotropic medications with TD as a side effect 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 psychotropic medication with TD as a side effect. This is more likely following the use of a long acting, injectable psychotropic medication associated with TD. 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:
  - The RN shall review the documentation of this diagnosis and inform the person's service coordinator of the diagnosis and treatment recommendations;
  - The nurse shall notify the person's support team, family, and service coordinator, if appropriate, guardian, advocate, and the DDS’s Health and Wellness Unit; and
  - The nurse shall ensure that all appropriate recommendations are implemented and documented in the person's health file.

- If person is diagnosed with 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.
  - 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 psychotropic medications with TD as a side effect.
  - When a decision is made not to reduce or discontinue the psychotropic medications with TD as a side effect, the treatment team must ensure that documentation details the following:
    - The risks versus benefits of not continuing the psychotropic medications with TD as a side effect and the consent for the medication clearly states that the person will continue to take the medication even though TD has been diagnosed.
    - Psychotropic medications must be renewed by the prescribing physician or NP every 30 days.

Prescriptions for psychotropic medications may be written in accordance with the following examples unless prohibited by the Food and Drug Administration (FDA) or any other applicable federal law concerning the prescription of medications.

- Example 1: A prescriber may meet with the person every 30 days, or more frequently, and renew the prescription at the time of the appointment.

- Example 2: A prescription for a 30-day supply of psychotropic medication may be written with up to two refills during a 90-day period without a scheduled office visit if the prescriber has determined that the continued use of psychotropic medication is safe, effective, and necessary.

- Example 3: Within a 90-day period, a medication prescription may be rewritten every 30 days without a scheduled office visit if the prescriber has determined that the continued use of psychotropic medication is safe, effective, and necessary.

There is no requirement for prescribers to schedule an office visit every 30 days in order to renew psychotropic prescriptions. The frequency of scheduled appointments within each 90-day period is determined by the prescriber in collaboration with the person (or the person's substitute healthcare decision maker) and the person's support team based on the person's clinical status.

The frequency with which the prescription will be renewed must be documented on either the provider's medical appointment consultation form or the DDS Psychiatry Appointment Consultation Form. The use of this form is optional, but recommended, and is available at https://dds.dc.gov/node/1447151 (Appendix 18).

- Psychiatry appointment consultation forms must be uploaded to MCIS under "Clinical Services" by the DDS provider of residential services. If the person does not have a residential services provider then the DDS provider that supports the person in the person's home is responsible for uploading the documentation to MCIS.

- 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.

The DDS Psychotropic Medication Review Form should be used to document mental health diagnoses, labs, status of current health concerns, behavioral functioning, side effect monitoring, review of risks, and medication changes. Please

	refer to https://dds.dc.gov/publication/psychotropic-medication-review-form (Appendix 9). • The prescriber should be consulted for information about potentially life-threatening side effects of psychotropic medications including but not limited to: ○ Agranulocytosis ○ Akathisia ○ Cardiac Arrhythmias ○ Dystonic Reactions ○ Metabolic Syndrome ○ Neuroleptic Malignant Syndrome (NMS) ○ Seizures Additional resource on the uses of psychotropic medications and side effects: *What Your Patients Need to Know About Psychotropic Medications* (3rd ed.) by RH Chew, RE Hales, and SC Yudofsky (2019), available at Amazon.com 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 assessment and treatment will be available for people with known or suspected psychiatric disorders. Licensed, board-certified psychiatrists or NPs shall provide assessment, diagnosis and treatment of psychiatric disorders. ***Applies to:*** All people receiving supports and services through DDA.	**Psychiatric Services** 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 or NP 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. When a provider nurse and/or a designee from the day services provider observes any deterioration in the person's functioning in between psychiatry appointments, the provider nurse for residential services shall: 1. Document the changes, 2. Immediately notify the prescriber, 3. Document that the prescriber has been notified of the changes, and 4. Document any new orders from the prescriber. If the person does not receive residential services, then the nurse for the provider agency that supports the person in the person's home shall document the changes and notify the prescriber. Significant changes may include, but are not limited to: • Changes in activity level • Exacerbation of psychiatric symptoms • Unusual body movements (i.e., tremors, motor restlessness) • Sleep changes • Appetite changes • Persistent change in mood • Suicidal ideation/behavior • Homicidal ideation/behavior • Escalation in challenging behaviors • Medication side effects • Repeated medication refusals • Deterioration in mental status • Emergency room visits for behavior • Psychiatric hospitalizations • Use of restraints	***Documentation:*** Psychiatric services will be documented in the physician progress notes, consultation forms, and the Psychotropic Medication Review Form by the residential provider or by the provider of in home services, for people living in natural homes.

- Police calls for behavior
- Abnormal laboratory examination results which may be related to psychotropic medication use
- Changes in medical status that may affect mental health issues, including the new diagnosis of a medical condition or the prescription of medications to treat a medical condition

One-time basis medication administered by a physician for sedation during a non-recurring medical appointment does not require a BSP. However, if sedation is used for a non-recurring medical appointment, the use of sedation for must be entered as an incident under “Use of Unapproved Restraints” in MCIS.

The DDS Psychotropic Medication Review Form shall be used to document the interdisciplinary review of behavioral and laboratory data as well as screening for side effects. Psychiatry Appointment Consultation Form Psychiatry Appointment Consultation Form.

- Page 1 of the Psychotropic Medication Review Form is the **Health Review** which is completed by a nurse.
- Page 2 of the Psychotropic Medication Review Form is the **Review of Behavioral Functioning** which must be completed with input from the behavior support clinician, if the person has a BSP.
- Page 3 of the Psychotropic Medication Review Form is the **Physician Report** which must be completed by the prescriber of psychotropic medication at the time of the quarterly medication review.

Residential providers and in home support providers shall document and provide information to the prescriber of psychotropic medication to assist the prescriber in assessing the effectiveness of the medication and the person’s response, including any side effects.

The DDS provider of residential services is responsible for completing Page 1 and Page 2 of the Psychotropic Medication Review Form for every psychiatry appointment, including the appointment for the quarterly medication review.

If the person does not have a residential services provider then the DDS provider that supports the person in the

	person’s home is responsible for completing Page 1 and Page 2 of the form. All three pages of each quarterly Psychotropic Medication Review Form are required to be uploaded to MCIS under “Clinical Services.” For people with BSPs, the two most recent quarterly Psychotropic Medication Review Forms must also be uploaded under the “BSP” tab for review by the RCRC at the time the BSP is uploaded for RCRC review. The documentation must be uploaded to MCIS by the DDS provider of residential services. If the person does not have a residential services provider then the DDS provider that supports the person in the person’s home is responsible for uploading the documentation to MCIS. The Psychotropic Medication Review Form and Health Passport should be reviewed by the person’s nursing staff prior to the appointment. Please refer to “***A CHECKLIST FOR COORDINATORS AND SUPERVISORS: Psychiatric and Behavioral Problems in Individuals with Intellectual Disability”,*** available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/A%20Checklist%20for%20Coordinators%20and%20Supervisors%20-%20Psychiatric%20and%20Behavioral%20Problems%20in%20Individuals%20with%20DD.pdf (Appendix 8). 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, QIDP’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.	

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:*** ***Required for:*** People residing in ICFs/IDD. People enrolled in a HCBS IDD 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 with a high acuity in home support service.	**Therapeutic Services: Physical, Occupational, Nutrition and Speech & Language Therapies** **Physical Therapy** Physical therapy (PT) services are available to diagnose, manage, and treat disorders of the musculoskeletal system. PTs work with people to address problems with ambulation, balance, positioning, and loss of functional independence. The goal of physical therapy 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. OTs 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; and • Be included in the ISP. The PT and/or OT, and SLP are responsible to: • 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 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, or other caregivers; • Record a progress note on each visit;	***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 RN.

- Conduct periodic examinations modifying treatments for the person, when necessary; and
- 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 PCP. 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 and the effectiveness of the diet. Any barriers to following the protocol (refusals of meals, behaviors that occur with the diet changes, etc.) should be tracked by weight charts and food intake log and documented by residential providers.

Weight records are kept for a person if a need is determined by the Nutritionist, Dietitian 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. Provider nurses shall monitor the weight records kept by staff to ensure accuracy and monitor for effectiveness of diets and changes in weight status.

ICF/IDD regulations require a minimum of quarterly evaluations by a registered dietician. 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/IDD regulations stipulate that only licensed dieticians can provide services. This excludes nutritionists. The HCBS IDD 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. 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 a comprehensive assessment of communication ability and asses for use of augmentative and alternative speech devices, methods, strategies, or the use of sign language and/or other expressive methods. Assist with recovery from a vocal disorder • A comprehensive assessment to determine the presence or absence of a swallowing disorder • 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 • Teach sign language and/or lip reading to people who have hearing loss The speech and language service provider will be responsible for providing written documentation. 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 pre-contemplation 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 different brand of cigarettes or decreasing their drinking signals that they have decided a change is needed.

Documentation:
The physician order for lifestyle changes shall be maintained in the Health Record by the residential provider.

Written documentation by staff in the form of reports, assessments, visitation notes, and progress notes are to be maintained in the Health Record by the residential provider.

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 by the residential nurse.

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

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:
Required for:
People residing in ICFs/IDD.
People enrolled in a HCBS IDD 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 with a high acuity in home support service.

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; and
- 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; or
- 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 (meaning 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; and • Care provided during and after the seizure activity. A daily seizure record documentation is recommended for all persons with diagnosis of seizure disorder who also receive seizure medications/Vagal Nerve Stimulator (VNS). An Adult Seizure Record Form & Seizure Tracker Log Form is available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/adult_seiz_record.pdf (Appendix 17).	

Standard 23	**Adaptive Equipment**	***Documentation:***
***Adaptive Equipment*:** 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. ***Applies to*:** All people supported by DDA.	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 ISP. Adaptive Equipment includes both durable medical equipment (DME) and assistive technology (AT) devices. • DME includes items such as wheelchairs, hospital beds, toilets aids/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. This also includes assistive devices necessary for sexual intimacy. • 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. **Assessments** A person will always need an assessment by a healthcare professional (i.e., PT, OT, 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 replacement or repair may need an assessment by a clinician	Orders for adaptive equipment and DME need to be noted in the PCP orders. For the adaptive equipment monthly checklist and tracking, the residential provider should use the system in MCIS Documentation indicating adaptive equipment assessment should be maintained in the medical record by the residential provider. The residential provider should provide handoff communication on any adaptive equipment for their individual to the Day Program.

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.

Provider and Service Coordination Responsibilities

Each provider staff member who supports a person with a disability must be familiar with all the adaptive equipment that the person may use. It is the responsibility of DSPS, QIDPs, 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.

The ICF/IDD or HCBS provider are responsible to ensure the acquisition repair and/or replacement of all adaptive equipment. For people living in their natural home their service coordinator will collaborate with the person and their support network to ensure the acquisition repair and or replacement of the 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. **Process for Submitting Adaptive Equipment Claims** For people who receive supports through the HCBS IDD 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 ICF/IDD, the provider is responsible for purchasing all needed non-custom adaptive equipment (e.g., standard wheelchairs, shower chairs, hospital beds, Hoyer lifts, etc.). ICF/IDD 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 of 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 or if the needs change, such as a significant decline in the person. The actual planning appropriately takes place outside of the actual ISP meeting. The person 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 caregivers. 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 Hospice Care** If in-home hospice is chosen, the contracted hospice nurse will develop a plan of care that will remain in the home and is to be followed by all members of the person's care team. **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 DDS supports 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, EMS, and Comfort Care Order.	***Documentation:*** Guidance on Hospice Care If in-home hospice is chosen, the contracted hospice nurse will develop a plan of care that will remain in the home and is to be followed by all members of the person's care team.

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 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.

Definition of Terms

What is DNR?

DNR stands for **"Do Not Resuscitate"** and, when included in an advance directive, instructs medical personnel not to provide 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.

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.

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.)

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.

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 Emergency Medical Services (EMS) Comfort Care Order-Do Not Resuscitate (CCO-DNR) Program at (202) 671-4222, also available at https://dchealth.dc.gov/service/ems-comfort-care-orderdo-

	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 DDS): http://gucchdgeorgetown.net/ucedd/complex/ *Additional information on End-of-Life planning called "Thinking Ahead" is available at https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/Thinking%20Ahead%20-%20End%20of%20Life%20Planning_2.pdf (Appendix 12).*	

Standard 25	**Alternative/Complementary Therapies**	**Documentation:**
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/IDD. People enrolled in a HCBS IDD waiver receiving residential habilitation, supported living, and host home services. ***Recommended for:*** People living independently or residing in their family home.	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 a doctor of medicine (MD), NP or doctor of osteopathy (DO) 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, NP, or DO. This documentation must be kept in the person's file.	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 what is sometimes known as the Fatal Four will require protocols to reduce risks.

Applies to:

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, which is why they are sometimes known as the Fatal Four. 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 these four conditions can be approached in the following manner to develop person centered interventions:

- Identifying the person's and healthcare team's learning needs related to the condition;
- 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;
- Identification of current support services in place to prevent or lessen the effect of the condition; and
- 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 by the SLP.

Factors that place a person at risk for aspiration and will require further evaluation:

Documentation:

The associated health condition must be documented in the Health Record and Training Records. Nursing HCMPs, HP and Assessments must be updated accordingly by the residential nurse to identify any status changes.

- 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;
- Gastro esophageal 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;
- Post-procedure with sedation;
- Impaired mobility that may leave a person unable to sit upright while eating; or
- 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 mealtimes.
- Keep in an upright position after meals for 45 minutes after meals 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 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): What to Swallow?" available at https://leader.pubs.asha.org/doi/10.1044/leader.FTR3.08202003.16.

“The Speech Pathologist and Swallowing Studies,” available at https://www.mypcnow.org/fast-fact/the-speech-pathologist-and-swallowing-studies/.

“Strategies for Improving Care for Patients with Advanced Dementia and Eating Problems: Optimizing Care Through Physician and Speech Pathologist Collaboration,” available at https://www.managedhealthcareconnect.com/content/strategi es-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 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 PT'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 3 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, see: https://www.niddk.nih.gov/health-information/digestive-diseases/constipation.

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," available at https://onlinelibrary.wiley.com/doi/abs/10.1002/j.2048-7940.2008.tb00234.x. "Water + Electrolytes: How They Prevent Dehydration," available at https://eletewater.co.uk/blogs/research/8029111-water-electrolytes-how-they-prevent-dehydration#.Xmo-2VHCHcs. Epileptic Seizures (follow guidelines for Seizure Disorder and Protocols-Standard 22)	

Standard 27 ***<u>Family Caregiver Health Promotion Activity Plans or HPAPs:</u>*** HCBS IDD waiver providers who offer High Acuity In-Home Supports shall develop HPAPs for people receiving this waiver service. Providers shall train the person, family and caregivers - including day program staff - on HPAPs and how to operationalize them. **Required for:** Anyone enrolled in the HCBS IDD waiver receiving High Acuity In-Home Supports. **Recommended for:** N/A.	**Family Caregiver Health Care Management Plans or Health Promotion Activity Plans (HPAPs)** Family Caregiver Health Care Management Plans, also referred to as Health Promotion Activity Plans (HPAPs) are diagnosis-specific documents developed by a provider RN for a person receiving High Acuity in Home Supports through DDA. HPAPs are designed to plan supports for a person based upon his or her health care diagnoses and prescribed treatment. They are individualized to the person and include a definition of the person's conditions, signs and symptoms, and a plan of action to address each condition. HPAPs summarize the person's diagnosis, care and treatment information, for use by the person and their caregivers, including family, other natural supports, and day program staff. A person may have multiple HPAPs, depending on their medical conditions. For example, a person may have one HPAP for seizure disorder, and another for hypertension. Protocols should also be included, for example seizure, fall or aspiration protocols. By following the treatment and care outlined in a person's HPAPs, and receiving training on them, a person, his or her QIDPs, DSPs whether at the person's home or during daily activities, and family should be able to maintain the person's optimal health within their scope of practice. More than 100 diagnostic examples are available at https://www.pchc.org/resources/hpaps. Please note that while the diagnostic examples may be used as the template when a person has the corresponding condition, the HPAP must be individualized to the person. The High Acuity In-Home Support provider is responsible for uploading completed HPAPs into MCIS under the Clinical Services tab. **HPAP Components** HPAPs are an effective way to plan health care activities for various diagnoses. They are developed by the provider's RN. HPAPs shall include useful general information on diagnoses and be individualized to a person's needs and address specific diagnoses in terms of: • Relevant body system • General definition • General signs and symptoms	***<u>Documentation:</u>*** For people who receive DDA High Acuity In-Home Supports, the provider's RN in cooperation with the person, family caregivers, QIDPs and DSPs, shall create HPAPs, aimed at improving the person's health care and health. The RN shall use the established template to individualize HPAPs for the person's diagnoses. The RN is responsible for documenting all required training on the HPAPs. HPAPs must be uploaded to MCIS.

- Signs and symptoms specific to the individual
- Details of the strategy needed to promote or support the person
  - Information on how to support the health condition
  - Who should be called for changes or problems in the person’s health condition
- What kind of documentation is tracked and who is responsible for follow-up?
- What type of ongoing training is needed for caregivers to support this person’s health condition? And for how long?
- Frequency of support
- Desired outcome
- Person (family member, caregiver, etc.) or agency responsible

HPAPs are living documents appropriate for both chronic and acute conditions involving diagnosis, care and/or treatment. For those new to these supports, HPAPs must be initiated by the RN within 30 days of admission. The RN’s signature and the date of any updates including annual reviews must be documented on the last page of the HPAPs. HPAPs shall be revised at least annually by the RN and presented at the person’s ISP meeting by the nurse or his/her designee. Subsequent revisions shall be made as needed, based on changes in the person’s health status. The HPAPs should be revised if the person receives new diagnoses and/or exhibits a change in health status, or the HPAP is deemed ineffective. These updates must be done within 7 days of identifying the new health concern.

Desired Outcomes

The HPAP includes the identification of Desired Outcomes. It is important to identify desired 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 HPAP
- Promotes the participation of the person in their own health care
- Clearly communicates the expectations for the plan of care
- Promotes accountability

- Desired outcomes:
- Focus on the person and are a part of person-centered thinking
- Consist of clear and concise statements
- Are measurable
- Are time-limited
- Present realistic goals
- Represent a mutual decision between the nurse, the person and any health care decision-maker

Role of Registered Nurses

RNs charged with creating HPAPs do not treat or care for a person as part of their HPAP responsibilities; the role is the distinct one: RNs train LPNs, QIDPs, DSPs, family members and other natural supports on their responsibilities outlined in the person's HPAPs to meet those responsibilities to improve health outcomes. RNs also train the trainers, meaning that RNs train LPNs and QIDPs on how to train others on the person's HPAPs. The RN may also train the family member to train other natural supports. Here are some examples. For migraines, while a physician may recommend one or more specific medications, the RN may include on the HPAP that the family ensure that the person rests in quiet, calm, dark environment with their head slightly elevated (see the HPAP for migraines). For diabetes, the nurse creating the HPAP might recommend that those involved in daily care of the person check the feet and skin are checked daily for red or open areas (see the HPAP for diabetes).

Below are the top three responsibilities for the RN in the development and implementation of HPAPs.

1. Cooperating with the person, LPNs, QIDPs, DSPs and family, the nurse will develop HPAPs in accordance with DDS's Health and Wellness Standards.
2. Presenting and explaining the HPAPs to the person, family, QIDPs and LPN, if available.
3. Providing training on diagnoses, treatment and care listed in HPAPs to the QIDPs and/ or LPNs, training the trainers, and coordinating such training with the QIDPs for the person, family and any other residents of the person's home who provide natural (unpaid) supports, and residential and day program staff. This training may be completed by the RN, or a QIDP or LPN who received train-the-trainer session on the HPAP by the RN.

4. Ensuring all paid support staff have requisite knowledge to carry out delegated functions.

Role of the Qualified Intellectual Disabilities Professional

The QIDP serves as an integral part of a health services team and supports professionals working collaboratively with a person, nurses and other health personnel, day services, DSPs and the person's family and other natural supports. In settings where RNs are part of the support team, the QIDP and the RN must work collaboratively. While the RN is responsible for the development of the HPAPs, the QIDP must be knowledgeable of all aspects of the plan and would be expected to reference the HPAP 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 QIDP must be knowledgeable about: (1) signs and symptoms to report to the RN or 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 HPAPs.

QIDPs And DSPs Must Know And Follow Protocols

In addition to knowing these critical reporting parameters, QIDPs 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 or the Heimlich maneuver.

The skills of the QIDP are essential to attaining the desired outcomes articulated within the HPAPs.

Role of Direct Support Professionals

The HPAPs delineate the interventions that are the responsibility of the DSP. The DSP needs to be able to demonstrate competency to complete interventions that relate to their assigned duties. The DSP is expected to reference the HPAP when discussing the health support needs of the person with the QIDP and the person's family or other caregivers.

The National Association of Direct Support Professionals Code of Ethics (https://www.nadsp.org/code-of-ethics-text/) 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 EMS.

DSPs need to be able to report observable changes in the person that may indicate a change in health states and address specific diet or activities of daily living needs outlined in the HPAP.

Observable Changes

DSPs need to be trained on the elements of *Stop and Watch* and reporting protocols for the person 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 3 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.

Standard 28 ***Supporting People Who Experience Trauma:*** People with disabilities are more likely to be exposed to traumatic events but less able to recover without significant supports from caregivers and providers. Supports for these persons are needed that quickly and effectively assess the potentially complex needs of the person and to coordinate recovery from trauma. Support teams, service coordinators and health care professionals are knowledgeable of assessment methods and evidence-based support strategies. ***Applies to:*** All people receiving services through DDA, especially those identified with exposure to traumatic events.	**Supporting People Who Experience Trauma** Trauma-informed care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist the re-traumatization of people. People with a disability are more likely to experience a traumatic event (such as abuse, neglect, injury) compared to their nondisabled peers but are less likely to be able to independently cope with such events and recover from trauma. Service agencies and health care professionals need to understand how to support a person when she/he has experienced a traumatic event, which can include a range of screening, assessment and treatment coordination supports. Each service agency should have a procedure in place across all service settings to address the needs of a person who has experienced trauma, which may include: • Developing organizational policies that include a framework for **Trauma-Informed Care**, which can include existing or modified policies and procedures, targeted staff training, and specialized support protocols; • Screening persons for trauma-related experiences and their potential impact (see GU Trauma Exposure & Symptom Record - *Appendix 20,* link below); • Creating a nurturing environment that promotes positive experiences, facilitates therapeutic relationships and emphasizes self-determination, choice and safety for the person; and • Providing access to healthcare specialists (i.e., psychologists, social workers, psychiatrists, nurses) who are familiar with supporting people who have experienced traumatic events. Persons exposed to traumatic events must receive timely assessments and evidence-based supports: • Persons exposed to known or recent traumatic events must be assessed with 24 hours to determine the impact of the traumatic experience; • Evidence-based trauma supports must be identified or described as needed; and	***Documentation:*** Documentation that provides evidence of coordination of trauma-related assessment and care will be included in the Health Record by the residential provider. This coordination of services should be reflected in the nursing, therapeutic service, individual support plan, primary care, and specialty care progress notes.

	- Trauma supports that manage the impact of the trauma and address the person's recovery must be integrated into the person's support plan. **Sources**: Substance Abuse and Mental Health Services (SAMHSA) site: https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.html. GU Trauma Exposure & Symptom Record, available at https://dds.dc.gov/node/1464066 (Appendix 20) and GU Trauma Informed Care Public Health Model for Developmental Disability Services available at https://dds.dc.gov/node/1464071 (Appendix 21).	

Standard 29 ***<u>Sexual Health & Intimacy:</u>*** People with disabilities have a right to experience and pursue healthy relationships. Providers, including nurses, QIDPs, DSPs; families; and a person's support team should recognize and support the sexual lives of people with disabilities. Nurses and support teams should be knowledgeable of sexuality and intimacy topics and preventative measures. ***<u>Applies to:</u>*** All people receiving services through DDA, especially those who have expressed interest in a sexual relationship, those who are sexually active, and those who have experienced sexual trauma, as well as people's parents, families and other natural supports.	**Sexual Health & Intimacy** People with disabilities have a right to express themselves sexually. This may include engaging in sexual behaviors, masturbation, being in an intimate relationship, birth control options, same sex relationships, starting a family, using an adapted device for sexual intimacy and more. Service agencies and health care professionals should understand how to support a person by providing education, screening and assessment tools. Providers should modify existing policies or procedures that are inconsistent with this Standard. Each service agency should have a procedure in place across all service settings to address the needs of a person who is sexually active or who has expressed interest in a sexual relationship, which should include: 1. Acknowledging that people are sexual beings with a range of sexual orientations consistent with the diversity of human expression who may express their sexuality in different ways; 2. Creating environments that promote positive experiences consistent with person-centered thinking, facilitating healthy relationships, including romantic and sexual relationships, and supporting choice and safety for the person; 3. Providing for targeted staff training and creating privacy and specialized support protocols for each person, as necessary; 4. Providing education on general concepts of sexuality and intimacy and, as needed, targeted supports on specific issues related to sexuality and intimacy as needed; 5. Using the *Nursing Health and Safety Assessment Form A* to identify sexual health and intimacy needs, available at https://dds.dc.gov/node/1466431 (Appendix 24); 6. Providing people with access to healthcare specialists (i.e., physicians, nurses, psychologists, psychiatrists, sex therapists and sex educators) who have experience in supporting people with disabilities who are sexually active to live healthy lives as sexual people. 7. Ensuring that people have access to: the full range of modern reproductive choices; education on sexually transmitted infections (STIs) and safe sex including HIV prevention, including Pre-Exposure Prophylaxis (PrEP); personal hygiene, adapted devices for sexual intimacy;	***<u>Documentation:</u>*** Documentation that provides evidence of coordination of sexual health and intimacy related assessment and education will be included in the Nursing Health and Safety Assessment Form A, Section: Sexuality.

	and lesbian, gay, bisexual, transgender and queer rights and relationships. People with disabilities who have recently engaged in consensual sex or been subjected to non-consensual sexual activity may need individualized supports such as a health need or risk assessment, education, counseling, modification to their person-centered plan, or support in making decisions about sexual behavior and reproduction.	