

District of Columbia  
Developmental Disabilities Administration

# **Health and Wellness Standards**

**Developed in collaboration with the  
Georgetown University Center for Child and  
Human Development – University Center on  
Excellence in Developmental Disabilities  
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# **Acknowledgement**

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<b><i>Table of Contents</i></b>		
<b>Standard Number</b>		<b>Page Number</b>
	Introduction	5
	Variances	7
1	Health Passport	8
2	Coordination of Health Care Services	10
3	Preventative Health Care	11
4	Individuals Experiencing Declining Health	12
5	Health Care Management Plan	13
6	Medical Consent	15
7	Reporting Critical Incidents	20
8	Behavioral Support Plan	21
9	Restrictive Procedures	22
10	Universal Precautions	23
11	Infections - MRSA/VRE/Hepatitis B	24
12	Annual Physical Exam	27
13	Dental Exam	29
14	Hearing Assessment & Hearing Aids	30
15	Vision/Eye Health Care	32
16	Immunizations	33
17	Medication Prescription & Administration	34
18	Psychotropic Medications	38
19	Psychiatric Services	42
20	Occupational Therapy/Physical Therapy/Speech & Language Therapy Services	43
21	Seizure Disorders and Protocols	46
22	Nutrition	47
23	Adaptive Equipment	49
24	End of Life Planning	52
25	Alternative/Complementary Therapies	53

<b><i>Appendices</i></b>		
1	Health Passport	
2	Health Forms 1, 2, 3	
3	Health Care Management Plan (HCMP)	
4	Development of the HCMP	
5	Nursing Assessment A & B and Interpretive Guidelines A & B	
6	MRSA Brochure	
7	Self Medication Assessment Tool	
8	A Checklist for Coordinators and Supervisors: Psychiatric and Behavioral Problems in Individuals with Developmental Disabilities	
9	Psychotropic Medication Review Form	
10	Transition of Care Guide	
11	DC Board of Nursing Delegation Tree	
12	"Thinking Ahead" – End of Life Planning	

<p><b><u>Standards:</u></b> Standards are requirements for some or all individuals receiving supports from DDA.</p> <p>Standards will be listed in this column and numbered accordingly, with a detailed explanation of the standard in the right-hand column.</p> <p><b><u>Applies to:</u></b> The individuals to whom the standard applies will be noted in this column.</p>	<p style="text-align: center;"><b>Introduction</b></p> <p>The Developmental Disabilities Administration (DDA) is responsible for the oversight and coordination of all services and supports for qualified persons with developmental disabilities in the District of Columbia.</p> <p>One of the key purposes of the <i>Health and Wellness Standards</i> document is to provide the information and tools necessary to advocate for the best possible health care and health outcomes for people with developmental disabilities, thus ensuring a good quality of life.</p> <p>The <i>Standards</i> do not focus on specific health conditions, but rather provide a guide for the assessment, planning, delivery and documentation of essential health supports. Individuals with disabilities and those individuals who support them must continually seek and be provided with health education and advocacy.</p> <p>Each designated agency, specialized service agency, and person or family who manages their supports has the responsibility to ensure that health services are provided and documented as appropriate.</p> <p>These responsibilities apply to the care of all individuals who receive supports whether in: ICFs-MR or Community Based Waiver services. The applicability of these guidelines for individuals living independently or with family members will vary.</p> <p>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).</p> <p>DDA’s expectations for health and wellness services emphasize the importance of:</p> <ul style="list-style-type: none"> <li>• Preventative health</li> <li>• Continual assessment for changes in health</li> <li>• Care coordination</li> </ul>	<p><b><u>Documentation:</u></b> The documentation of health and wellness supports is an essential part of the provision of quality care.</p> <p>The location of health and wellness related documentation will be noted in this column.</p>
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	<p>Tools for accomplishing these goals include:</p> <ul style="list-style-type: none"><li>• Nursing Assessment</li><li>• Health care management planning</li><li>• Health Passports to communicate health issues</li><li>• Health Form 1 to guide the scheduling of preventative screening and assessments</li></ul>	
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<p><b><u>Variations:</u></b>  Variations to the <i>Health and Wellness Standards</i> can be made with the documented approval of an involved medical professional.</p> <p><b><u>Applies to:</u></b>  All individuals receiving DDA funded Services.</p>	<p><b>Variations</b></p> <p>Circumstances may occur for which application of a standard may not be indicated or may not be in the best interest of an individual. When this occurs, there should be discussion(s) between the individual, the health care provider, support team members, and health care decision-maker (if there is one).</p> <p>Variations cannot be for the convenience of the support team or health care provider.</p> <p>The right of an individual to refuse treatment is respected. However, DDA is responsible to ensure that the individual's decision is based on an informed choice.</p> <p>Examples of situations where a variance might be indicated include:</p> <ul style="list-style-type: none"> <li>• A healthy person may need less frequent physical exams than on an annual basis</li> <li>• Contractures or other physical difficulties may prevent certain testing</li> <li>• Certain preventative tests may not be desired in the presence of a terminal illness or advanced age</li> </ul> <p>If a variance occurs secondary to difficulties such as fear of blood drawing, Pap test, etc., then there must be information in the individual's health file that indicates attempts have been made to desensitize the individual, as well as the effectiveness of these actions, and plans for review.</p>	<p><b><u>Documentation:</u></b>  Any variance in health and wellness services needs to be documented in the health record. This documentation must include the following: rationale for the variance; any related discussions between the individual, health care provider, support team members, and health care decision-maker; and any actions or plans to be taken to address the variance.</p>
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<p><b>Standard 1</b></p> <p><b><u>Health Passport:</u></b> A current emergency fact sheet, following the standardized <i>Health Passport</i> format, will be accessible and available in all files (including home, agency, day program, etc.), and to all individuals involved in a person’s supports.</p> <p><b><u>Applies to:</u></b> <b><u>Required for:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p> <p><b><u>Recommended for:</u></b> The Health Passport is recommended for Individuals living independently or in a family home. The Health Passport document will be introduced to the individual and family member by</p>	<p><b>Health Passport</b></p> <p>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.</p> <p><i>A Health Passport</i> serves this purpose, whether available on paper or in an electronic form.</p> <p>The required information to be included in the <i>Health Passport</i> includes:</p> <ol style="list-style-type: none"> <li><b>1. Demographic Information</b> Individual’s name, address, phone number, date of birth, Medicaid/Medicare numbers, “Do Not Resuscitate/Do Not Intubate” status, agency number, and personal information (height, weight, race, gender, hair and eye color).</li> <li><b>2. Contact Information for :</b> <ul style="list-style-type: none"> <li>• Health care decision-maker, next of kin, or legal guardian</li> <li>• Provider agency, and designated staff (QDDP, Registered Nurse)</li> <li>• DDA Service coordinator</li> <li>• Health care providers (Primary care physician, dentist, psychiatrist, psychologist, medical specialists (i.e. cardiologist, neurologist, gynecologist, etc.)</li> </ul> </li> <li><b>3. Functional Information</b> <ul style="list-style-type: none"> <li>• Cognitive skill level</li> <li>• Adaptive skill level and adaptive equipment (i.e. communication board, walker, cane or specialized eating utensils)</li> <li>• Communication level and methods (This section must impart to hospital staff an individual’s communication style.</li> </ul> <p>For example, does the individual use echolalia, tend to answer “yes” to all questions, or is able to</p> </li> </ol>	<p><b><u>Documentation:</u></b> A copy of the current <i>Health Passport</i> will be maintained at an individual’s residence. It is recommended that a current portable copy of the <i>Health Passport</i> accompany an individual to day and/or vocational services, to all medical appointments, and if applicable, outings in the community.</p>
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<p>the Service Coordinator.</p>	<p>answer many questions about their symptoms and history.)</p> <ul style="list-style-type: none"> <li>• Diet, food intolerance, texture information</li> <li>• Ambulation status (i.e. walks, needs assistance, non-ambulatory)</li> </ul> <p><b>4. Consent Procedures Information</b></p> <ul style="list-style-type: none"> <li>• Capacity to make medical decisions</li> <li>• If applicable, contact information for substitute health care decision maker</li> </ul> <p><b>5. Medical Information</b></p> <ul style="list-style-type: none"> <li>• Allergies (Drug, food; include emergency treatment, if indicated)</li> <li>• Special Precautions (Such as a visual or hearing impairment or special turning and positioning schedules.)</li> <li>• All current medical diagnoses and resolved medical diagnoses. This includes diagnoses that may be temporary, such as a urinary tract infection, MRSA infections, etc. so that a health care provider seeing someone for the first time has an accurate reference of current and past health conditions.</li> <li>• Medical Problem list (specific up-to-date information about all past medical problems, surgeries, special treatments including dates and current status)</li> </ul> <p><b>6. Vaccine Information</b></p> <ul style="list-style-type: none"> <li>• Include type, dates, source, and vaccine lot</li> </ul> <p><b>7. Medication Information</b></p> <ul style="list-style-type: none"> <li>• Medication names, start dates, dosages, times, routes, reason for medication and discontinuation dates</li> </ul> <p>All of this information is important, particularly when an individual is hospitalized and staff needs to be made familiar with an individual's communication style and ambulation status pre-hospitalization.</p> <p>All support staff must be oriented to the importance of the <i>Health Passport</i>, and be familiar with the need to make sure that this document accompanies the individual to all medical appointments and</p>	
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	<p>emergency room visits.</p> <p>In the emergency room, and if the individual is admitted to the hospital, staff must be sure to advocate that the <i>Health Passport</i> follows the individual in transit from the ER to the unit and that the receiving hospital staff is knowledgeable about its contents.</p> <p>For individuals living independently or in a family home, the <i>Health Passport</i> is optional. However, it is the responsibility of the service coordinator to educate the individual and/or their health care decision-maker about the benefits of the <i>Health Passport</i> and to provide assistance in its development and maintenance of current information.</p> <p>For individuals receiving day/vocational services, the current <i>Health Passport</i> will be developed and maintained by the residential services provider and sent to the day/vocational provider. Coordination will be needed between the residential staff and the day/vocational services provider to ensure that the Health Passport is current and includes the most up-to-date information.</p> <p>Technical assistance can be obtained from the DCHRP or DDA Health and Wellness registered nurses.</p> <p><b>Source:</b> The <i>Health Passport (Appendix 1)</i> document is available at: and <a href="http://dds.dc.gov">http://dds.dc.gov</a></p>	

<p><b>Standard 2</b></p> <p><b><u>Coordination of Health Care Services:</u></b> Health care delivery typically requires services from multiple providers working across a variety of systems. Care coordination is needed to ensure that services meet the complex needs of individuals and that residential support teams and service coordinators are knowledgeable of services received from all systems.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA.</p>	<p><b>Coordination of Health Care Services</b></p> <p>Coordination of health care services is the responsibility of the residential service provider. This responsibility will be directed by a registered nurse (RN) even if certain aspects of this responsibility are delegated to other staff. When delegating, the RN needs to be sure that the staff has the capacity to perform the necessary tasks, including oral and written communications and ability to interact with community agencies (See Board of Nursing Delegation Tree in the Appendix.).</p> <p>Each service agency, and each registered nurse needs to have a process in place to ensure that all standing recommendations are periodically reviewed to ensure that they are adequate, and eliminate unnecessary, although perhaps, historic, recommendations. Each service agency should have a procedure in place across all service settings to maintain current <i>Health Passports</i>, paying special attention to the accuracy of:</p> <ul style="list-style-type: none"> <li>• Clarity of who is the health care decision maker</li> <li>• Current contact numbers (for a 24 hour period) of substitute decision makers</li> <li>• Current contact information for PCP and specialists, including psychiatrist</li> <li>• Current medications</li> <li>• Updated list of medical problems</li> <li>• It is suggested that whatever staff person is responsible for taking medical orders for pharmacy purposes should modify the health passport at the time the order is started. For new health problems, diagnoses should be confirmed with the primary care provider.</li> </ul> <p>For individuals who do not receive nursing services, the service coordinator should work with the individual and their support team to maintain a <i>Health Passport</i>. This can be taught to the family member responsible for care or health care decision-making. However, individuals and families reserve the right to decline this service.</p> <p>The transition from hospitalization back to the home can be a time period where the person is at high risk</p>	<p><b><u>Documentation:</u></b> 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.</p>
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	<p>for adverse outcomes. Good communication among the interdisciplinary team and the implementation of consistent processes can reduce the risks associated with this transition period. <i>The Transition of Care Guide</i> was developed to assist community support providers, service coordinators and health care decision makers in obtaining the information needed to promote safe health care transitions from the hospital or long term care facility to the home setting.</p>	
<p><b>Standard 3</b></p> <p><b><u>Preventative Health Care:</u></b> Preventative health care focuses on optimizing an individual’s potential for health, function, and overall well-being. Unless a variance can be documented, health practitioners are expected to adhere to the USPSTF Guidelines.</p> <p><b><u>Applies to:</u></b> <b><u>Required for:</u></b> Individuals residing in ICFs-IDD. Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p><b>Preventative Health Care</b></p> <p>DDA’s requirements for preventative health screening by age and gender are found on Health Form 1. Health Form 1 represents the recommendations of the U.S. Preventative Screening Task Force (USPSTF) Guidelines. All preventative screenings should be recorded on Health Form 1. (See Appendix.)</p> <p>If an individual requires a variance from the USPSTF recommended screenings, the rationale for this variance needs to be documented in the record by a primary care provider.</p> <p><i>Health Form 2</i> (Direct Observation) and <i>Health Form 3</i> (Diagnostic Review) are supplemental forms to be used for assuring that individuals are receiving quality care. <i>Health Form 2</i> (Direct Observation) is generally completed by the direct support professionals to assist in the recording of health-related information, and for communicating recent health changes to a supervisor or health care provider. (See Appendix)</p> <p><i>Health Form 3</i> (Diagnostic Review) offers an instrument to organize a systematic review of an individual’s current assessments, physical exam, specialists’ reports, and medical intervention in a systemic way. (See Appendix)</p> <p>While the use of Health Form 1 is required, the use of <i>Health Forms 2 and 3</i> is optional, but highly recommended.</p>	<p><b><u>Documentation:</u></b> Health Form 1, which is the required form for documentation of preventative health screenings, is to be maintained in the Health Record.</p>

<p><b>Recommended for:</b> Preventative health care is recommended for Individuals living independently or in a family home.</p>	<p>Health Forms 1, 2, and 3 are available at: <a href="http://dds.dc.gov">http://dds.dc.gov</a></p>	
<p><b>Standard 4</b></p> <p><b><u>Support during Declining Health:</u></b> All individuals will receive support from health care providers, residential support staff and DDA service coordinators to ensure that changes in health care needs are adequately addressed.</p> <p><b><u>Required for:</u></b> All individuals receiving services from DDA.</p>	<p><b>Individuals Experiencing Declining Health</b></p> <p>Staff that interact with an individual on a regular basis are responsible for knowing the typical patterns of that individual’s life in order to detect any changes that need to be referred to the primary care provider.</p> <p>Depending on the level of supports received and by whom, either residential staff, nursing personnel or the service coordinator will be responsible for ensuring that all changes are thoroughly documented to assist the PCP and/or medical specialists in the diagnosis, treatment and evaluation of the health situation.</p> <p>The service coordinator working in collaboration with the individual, health care decision-makers, guardian (if named), and residential agency staff will ensure that:</p> <ul style="list-style-type: none"> <li>• The PCP conducts a timely and adequate medical evaluation to identify the etiology of the problem(s);</li> <li>• The PCP makes timely referrals to medical consultants and specialists to diagnose and treat the condition(s); and</li> <li>• Any recommendations resulting from such visits are acted upon in a timely manner consistent with the interests and health care needs of the individual.</li> </ul> <p>The findings from the PCP and medical specialists need to be integrated into a comprehensive plan of</p>	<p><b><u>Documentation</u></b> For individuals experiencing a decline in health, a comprehensive plan of care must be documented by the PCP, the DDA Service Coordinator and/or residential support registered nurse in the health record progress notes.</p> <p>Deferral or decline of any health recommendation made by the PCP or specialists must be thoroughly documented in the health record progress notes.</p>

	<p>care that is reviewed by the interdisciplinary team that includes the individual and their health care decision-maker (if one is needed). The comprehensive plan of care needs to include information on the individual's current status, any actions to be taken or not taken, rationale for these actions, an explanation of risks and benefits, and issues that may constitute a change in the direction of care.</p> <p>If a recommendation by a specialist is going to be deferred due to the best interest of the individual or a decision by the individual or their health care decision maker to decline treatment, that information must be thoroughly documented in a consultation report or progress note.</p> <p>Any change in function may require the interdisciplinary team to reconvene an ISP meeting to plan for additional supports or changes in the individual's current routine, for example a temporary respite from a job or day program. Consideration must also be made as to whether the illness necessitates additional support in health care decision making. For example, the individual may need temporary support to make decisions or even the appointment of a temporary guardian. (See Section 6 on Medical Consent.)</p> <p>The entire interdisciplinary team should evaluate what supports are needed to maintain a good quality of life consistent with the individual's personal preferences to include but not be limited to pain management, nutritional intake, recreation, spiritual support and access to friends and family.</p> <p>DDA offers technical assistance to individuals and their support teams to assist them during periods of functional decline through the Health and Wellness staff. Indications for consulting these resources include:</p> <ul style="list-style-type: none"> <li>• Frequent use of emergency room or hospitalizations</li> <li>• Newly diagnosed, serious health conditions</li> <li>• Major chronic conditions with a likelihood of poor outcomes</li> <li>• Lack of consensus regarding diagnosis or</li> </ul>	
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	<p>treatment</p> <ul style="list-style-type: none"> <li>• Sudden, unexplained behavior changes</li> <li>• Rapid decline in functional skills that may be related to poor health.</li> </ul> <p>Any such changes to service type, frequency, or duration in waiver services requires a team meeting, amendment to the ISP and the HCBS plan of care.</p>	
<p><b>Standard 5</b></p> <p><b><u>Health Management Care Plan (HMCP):</u></b> All individuals receiving nursing services via an ICF-IDD or HCBS Waiver should have a HCMP developed.</p> <p><b><u>Required for:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p><b>Health Management Care Plan</b></p> <p>The Health Care Management Plan (HCMP) is a comprehensive and individualized document used to summarize an individual’s health needs and outlines interventions required to maintain optimal health.</p> <p>The HCMP will address health concerns that impact individuals beyond the residential setting, to include the day/vocational supports.</p> <p>The HCMP is developed or amended during the annual Individual Service Plan (ISP) process and is attached as an addendum to the ISP.</p> <p>The HCMP is used to guide the implementation of all healthcare activities across multiple settings and should be incorporated within the ISP. For example, for an individual newly diagnosed with diabetes, the information that is needed to safely address and manage the individual’s health concerns in both the residential and day/vocational settings needs to be incorporated into the HCMP.</p> <p>The HCMP is based upon data gathered from the following sources:</p> <ul style="list-style-type: none"> <li>• Health Form 1 – a record of preventative health screenings</li> </ul>	<p><b><u>Documentation:</u></b> 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 individuals with changing health issues.</p>

- Health Form 2 (use of form is optional) – a record of observations by direct care staff
- Health Form 3 (use of form is optional) – chart review of medical diagnoses
- Nursing Assessment – The RN must choose between one of two formats to use (See below.).

A new HCMP shall be developed annually by the registered nurse and presented at the individual’s ISP meeting by the nurse or his/her designee. If the HCMP is a computer-based, with each annual ISP, a date and electronic signature should 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”. If the HCMP is part of an electronic medical record system – refer to your agency policy for electronic signature guidelines.

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 registered nurse, in ICF/IDD settings.

The HCMP must be updated more frequently if the individual 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 to the HCMP should be done within 7 days of the identification of the new health concern. In the situation of urgent health concerns, the HCMP should be updated immediately.

“No Adjustments/changes” should be written if there are no adjustments/changes at the time of the quarterly review.

For new admissions to the agency, the HCMP must be

	<p>initiated by the registered nurse within 30 days of admission.</p> <p>The registered nurse's signature and the date of any updates including the quarterly reviews must be documented on the last page of the HCMP. A signature represents that the registered nurse has reviewed the updated HCMP.</p> <p>If an electronic record system is in place, follow agency procedures to determine what constitutes an electronic signature.</p> <p><i>For information and guidance on developing HCMP - refer to the "Developing Health Care Management Plan" document in the Appendix.</i></p> <p><b>Nursing Assessment</b></p> <p>There are two types of nursing assessment tools that are to be used to develop the HCMP. Form A is to be utilized by a Registered Nurse (RN) in assessing adults with significant ID/DD disabilities. This assessment is designed for individuals needing an ICF level of care or 24 hour staff supports. In addition, the Director of Nursing in any setting may decide to use this form in order to best assess an individual's health care status. (See Nursing Health and Safety Assessment Form A Interpretive Guidelines in the Appendix.)</p> <p>Form B is to be utilized by a Registered Nurse (RN) in assessing adults with ID/DD disabilities living in less restrictive environments. It is designed for individuals receiving 20 hours or less of staff support each week. (See Nursing Health and Safety Assessment Form B Interpretive Guidelines in the Appendix.)</p> <p>Whether to use Nursing Assessment Form A or Form B for an individual, is always at the</p>	
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	<p>discretion of the Director of Nursing in that setting. Both assessments will enable the RN to develop desired health outcomes for the Health Management Care Plan (HCMP). The HCMP is the concluding part of this assessment, and is an integral part of it. No assessment will be considered complete unless the HCMP is attached.</p> <p>A nursing assessment should be completed as part of the initial Individual Support Plan and revised annually. Any time within that 12 month period if there is a significant change in health condition, the nursing assessment will need to be revised. Notwithstanding, focused assessments may be needed at any time to detect changes in health. The nursing assessment process described in this document is related to a comprehensive assessment that leads to the identification of health problems and expected outcomes, the creation of a Health Care Management Plan and the implementation and evaluation of that plan of care through an interdisciplinary process.</p>	
<p><b>Standard 6</b></p> <p><b><u>Medical Consent:</u></b> Consent from the individual or his/her health care decision maker (if there is one) is required prior to medical treatment, proposed changes in medical treatment, or proposed changes/additions to medication regimens.</p> <p>The individual or</p>	<p><b>Medical Consent</b></p> <p>Some people have the capacity to give medical consent. Capacity is the mental ability to understand the nature and implication of a decision (that there is a choice to be made) and the information (the alternatives) being presented; as well as, the ability to communicate that decision or give informed consent.</p> <p>Individuals who are unable to give consent, may have a:</p> <ul style="list-style-type: none"> <li>• substitute healthcare decision maker</li> <li>• permanent limited guardian for health care decisions</li> <li>• temporary emergency guardian for healthcare decisions</li> </ul> <p><i>A Substitute Healthcare Decision Maker*</i> is any individual authorized, by statute or common law, to</p>	<p><b><u>Documentation:</u></b> Copies of medical consent forms will be maintained in the Health Record.</p>

<p>his/her medical decision maker is also informed of any changes in health status.</p> <p><b><u>Applies to:</u></b>  Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p>make decisions on behalf of another person to give or refuse consent to medical treatment options recommended by the person’s personal physician. The decision to give or not give consent is based on the known best wishes of the individual, if this is not known or can’t be determined, the decision should be based on the good faith belief as the best interest of the person.</p> <p>*For individuals who <u>do not</u> have an identified substitute healthcare decision maker – refer to DDA Policy 4.5 “<i>Substitute Decision-making for Emergency Care and Urgent Care Medical Needs</i>”.</p> <p><i>A Permanent Limited Guardian for Health Care Decisions</i> is an individual appointed by a court order to make official decisions based on the substituted judgment as a guardian. This may include, but is not limited to an individual’s parents, siblings, next of kin, court-appointed advocate or court-appointed probate attorney.</p> <p><i>A temporary emergency guardian for healthcare decisions</i> is an individual who is appointed by the court to make medical decisions based on substituted judgment as a guardian for someone else for a specified period of time, and is usually appointed in an emergency care or urgent care situation. Health care decision makers and guardians are an important part of an individual’s team.</p> <p><b>General Guidelines Related to Medical Consent</b></p> <p>Except in emergency cases, the decision maker or guardian must be notified of appointments with the primary physician and other health care providers (e.g., psychiatrist, neurologist, etc.) prior to the visit.</p> <p>Consent from the individual or his/her medical decision maker/guardian (if there is one) to administer prescribed medications must be obtained prior to starting the medications.</p> <p>The following information is shared or explained to the person or his/her medical decision maker/guardian:</p> <ul style="list-style-type: none"> <li>• When medications may have significant side effects or are new or controversial. A plan to track</li> </ul>	
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	<p>or monitor the medication and its effects needs to be implemented.</p> <ul style="list-style-type: none"> <li>• Information regarding the risks associated with psychiatric medications should be outlined by the prescribing psychiatrist on the Universal Psychotropic Review form and maintained in the health record. The person or guardian needs to know how the physician will monitor for side effects. The service coordinator or registered nurse may need to facilitate communication between the person/guardian and the physician.</li> <li>• It is the responsibility of all staff supporting an individual to know the possible side effects of medications and the protocol to follow for reporting any observed side effects.</li> <li>• The service coordinator or registered nurse needs to inform the guardian when tests (other than routine) are ordered, especially if a problem is suspected. If the individual is their own guardian, the reasons for the tests need to be explained in a manner that ensures the information is clearly communicated.</li> </ul> <p>Source: DDA Policy 4.5 “Substitute Decision-making for Emergency Care and Urgent Care Medical Needs”</p>	
<p><b>Standard 7</b></p> <p><b><u>Incident Reporting:</u></b> All individuals served by DDA will be monitored for neglect, harm or abuse and all suspected incidents reported to DDA’s Incident Management Enforcement Unit.</p> <p><b><u>Applies to:</u></b> All employees of DDA, all individual agencies that</p>	<p><b>Reporting Critical Incidents</b></p> <p>It is the policy of DDA to ensure that all individuals receiving services as part of the DDA service delivery system are protected from neglect, harm, and abuse.</p> <p>It is essential for providers to implement and maintain an incident management system, and report critical incidents to DDA.</p> <p>There are two types of reportable incidents:</p> <ul style="list-style-type: none"> <li>• Reportable Incident: A significant event or situation involving an individual that requires an internal investigation by the provider (i.e. property damage, medication errors, hospitalization, physical injury, vehicle accident, ingestion of harmful substances, burn, others).</li> <li>• Serious Reportable Incident: A significant event or situation that requires immediate notification,</li> </ul>	<p><b><u>Documentation</u></b> Incident reports are never part of the medical record.</p> <p>Incident reports are to be filed DDA MCIS.</p> <p>Follow agency procedures when filing copies of incident reports within an agency</p>

<p>provide services to persons with developmental disabilities through funding, contract, or provider agreement with DC government.</p>	<p>review, and/or investigation by internal and external authorities (i.e. death, abuse, neglect, serious physical injury, medication errors, improper use of restraints, theft of personal property/funds, other).</p> <p>Source: DDS Incident Management and Enforcement Policy and Procedure</p>	
<p><b><i>Standard 8</i></b></p> <p><b><u>Positive Behavior Support:</u></b> All community provider agencies shall have a written policy and procedure for behavior support that utilizes individualized positive behavior support and prohibits aversive practices.</p> <p><b><u>Applies to:</u></b> All DDS employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide service and supports to individuals with disabilities.</p>	<p><b>Behavioral Support Plan</b></p> <p>Positive behavioral supports plans are to be developed when:</p> <ul style="list-style-type: none"> <li>• An individual exhibits behaviors that pose a threat to themselves or others</li> <li>• An individual exhibits behaviors that interfere with the attainment of learning goals or personal outcomes identified through the ISP process</li> <li>• An individual has been prescribed a psychotropic medication for behavior support</li> <li>• An individual has been subject to emergency restrictive controls or restraint due to a behavioral crisis</li> </ul> <p>The decision to develop a BSP must be made by the ISP team in conjunction with the individual and/or his/her guardian. The plan is developed by a licensed psychologist or clinical social worker, in conjunction with the ISP team and is integrated into an individual’s ISP.</p> <p>A functional assessment of behavior must precede the developmental of the plan.</p> <p>The components of a functional behavioral assessment and BSP, and the provider implantation guidelines are outlined in DDS Policy Number 6.3 “Positive Behavior Support”.</p>	<p><b><u>Documentation</u></b> Documentation of a functional assessment of behavior, and the Behavioral Support Plan (BSP) and will be maintained in a separate section of the Health Record.</p> <p>Per agency policy, a copy will be maintained in an easy to access record for staff to refer to the plan as needed.</p>

	Source: <i>DDS Policy . “Positive Behavior Support”</i>	
<p><b>Standard 9</b></p> <p><b><u>Restrictive Procedures:</u></b> The use of restrictive interventions is a last resort to modify behavior that presents a danger to self or others and shall only be used as a behavior change technique if included in a Positive Behavior Support Plan.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA</p>	<p><b>Restrictive Procedures</b></p> <p>All restrictive physical interventions shall have undergone intense scrutiny to provide an approach that balances the safety and rights of the individual exhibiting the behavior with the safety of others involved in the situation.</p> <p>All community provider agencies shall have and implement a written policy for restrictive behaviors in accordance with <i>DDS Policy</i></p> <ul style="list-style-type: none"> <li>• Behavior Support Policy and Procedures</li> <li>• Human Rights Policy</li> <li>• Human Rights Advisory Committee Procedure</li> <li>• Restrictive Control Review Committee Procedures</li> <li>• </li> </ul> <p>The use of mechanical restraints and protective equipment are permitted only to prevent severe self-injury or serious bodily harm to others when no less restrictive method for protecting the individual has been shown to be effective. Mechanical restraint must be authorized in writing by a licensed health care practitioner, who specifies the duration for its use, the circumstances under which the restraint is authorized and the frequency for staff monitoring of the individual being restrained.</p> <p>The specific standards, protocols, and procedures to be followed when considering or using restrictive procedures are outlined in <i>DDS Policy</i></p> <ul style="list-style-type: none"> <li>• <i>Source: DDS Policy</i></li> <li>• Behavior Support Policy and Procedures</li> <li>• Human Rights Policy</li> <li>• Human Rights Advisory Committee Procedure</li> <li>• Restrictive Control Review Committee Procedures</li> </ul>	<p><b><u>Documentation:</u></b> Documentation of the approval of the use of restrictive procedures by the agency’s human rights committee will be maintained in the Health Record.</p>

<p><b>Standard 10</b></p> <p><b><u>Universal Precautions/ Bloodborne Pathogen Training:</u></b> It is a federal requirement that Bloodborne Pathogen training be presented to employees with the potential for occupational exposure. This training must be provided in accordance with the requirements of the Occupational, Safety, and Health Administration (OSHA). Designated agencies must have a written policy consistent with the OSHA rules.</p> <p><b><u>Applies to:</u></b> All DDS employees, subcontractors, providers, vendors, consultants, volunteers, and governmental agencies that provide service and supports to individuals with disabilities.</p>	<p><b>Universal Precautions/ Bloodborne Pathogen Training</b></p> <p>"Universal precautions," as defined by CDC, are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other 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.</p> <p>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, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).</p> <p>All agencies must comply with Occupational, Safety, and Health Administration (OSHA) requirements related to blood borne pathogens and universal precautions.</p> <p>According to OSHA Regulation 29CFR, 1910.1030, all employer agencies must:</p> <ul style="list-style-type: none"> <li>• Provide an initial Bloodborne Pathogen training, and annual retraining, for all employees.</li> <li>• Provide training at no cost to employee and during work hours</li> <li>• Provide additional training if modification of tasks or new task occur that may affect occupational exposure</li> <li>• Make copies of the agency's Exposure Control Plan available to all employees</li> <li>• Offer the Hepatitis B vaccine, at no cost, to all employees with potential exposures, within 10 days of their initial work assignment.</li> <li>• Provide immediate post-exposure evaluation to all employees with an exposure incident</li> <li>• Provide personal protective equipment (e.g. gloves, gowns, masks, as needed.</li> </ul> <p>A record of the training and annual retraining for all workers is required.</p>	<p><b><u>Documentation:</u></b> Documentation of bloodborne pathogen training sessions will be maintained in agency training records. A copy of the agency Exposure Control Plan must be available to all employees.</p>
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	<p>In accordance with OSHA regulations, the Hepatitis B vaccine is offered to all DDA employees.</p> <p>Responsibility for payment for non-DDA employees is the responsibility of the employer or the individual/organization contracting for services.</p> <p><i>Source: OSHA Regulation 29CFR, 1910.1030</i></p>	
<p><b><i>Standard 11</i></b></p> <p><b><u>Management of Infections:</u></b> Individuals with antibiotic resistant bacteria, who do not require hospitalization for an acute infection or co-morbid 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 individual. Individuals with a MRSA or VRE colonization or infection shall not be refused services based on his or her MRSA or VRE status.</p> <p><b><u>Applies to:</u></b></p>	<p><b>Management of Infections</b></p> <p><b>MRSA and VRE</b> Antibiotic resistant bacteria such as Methicillin Resistant Staph Aureas (MRSA) and Vancomycin Resistant Enterococci (VRE) are the most commonly encountered drug-resistant infections in individuals residing in non-health care facilities, such as long-term care facilities. In recent years, there has been an increased incidence of these infections which can be acquired in both the health care and community settings.</p> <p>In the health care setting, MRSA occurs most frequently in individuals with a weakened immune system, and can occur as a wound infection, urinary tract infection, bloodstream infection, and pneumonia. It is transmitted by direct person-to-person contact, often on the hands of caregivers. In the community setting, the infection usually manifests itself as a skin infection (pimples and boils) in otherwise healthy people.</p> <p>VRE usually comes from the individual’s own bowel flora, and can be spread by direct individual-to-individual contact or on the hands of caregivers.</p> <p>Individuals may have a:</p> <ul style="list-style-type: none"> <li>• MRSA or VRE “colonization” (the organism is present, but not causing illness)</li> <li>• MRSA or VRE infection (the organism is present and causing illness).</li> </ul> <p>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.</p>	<p><b><u>Documentation:</u></b> Information related to management and individual response to treatment will be documented on the HMCP and in the nursing and physician progress notes.</p>

<p>Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p>Individuals with antibiotic resistant bacteria, who do not require hospitalization for an acute infection or co-morbid condition, can be safely cared for and managed at home by use of standard universal precautions.</p> <p>These management strategies include</p> <ul style="list-style-type: none"> <li>• Hand washing with soap and water after physical contact with the colonized or infected individual.</li> <li>• Towels used for drying hands should only be used once</li> <li>• Disposable gloves should be worn if contact with body fluids is expected, and hands should be washed after removing the gloves</li> <li>• Keep draining wounds covered with a bandage</li> <li>• If the individual has draining wounds or difficulty controlling bodily fluids - gloves should be worn and a private room considered</li> <li>• Linens should be changed and washed on a routine basis</li> <li>• Do not share razors, towels, washcloths, or clothing</li> <li>• The individual's environment should be cleaned routinely</li> <li>• Instruct individuals to observe good hygiene practices</li> </ul> <p>Colonized and infected individuals should be encouraged to participate in their usual social, and therapeutic activities, if draining wounds are present they should be covered.</p> <p><u>Source: CDC (2004)</u>  <u>For additional information on MRSA, see brochure in Appendix.</u></p> <p><b>Clostridium Difficile (C. difficile)</b></p> <p>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,</p>	
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toxic megacolon, perforations of the colon, sepsis, and death. At risk individuals 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 individuals 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 individual in a private room if available
- Perform hand hygiene (soap and water wash has been shown to be more effective than alcohol-based hand rub or soap in preventing spore-forming bacteria)
- Use gloves during care
- Use gowns if soiling of clothes is likely
- Dedicate equipment whenever possible
- Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices that are likely to be contaminated with feces and surfaces that are frequently touched.

*Source: CDC (2005)*

### **Hepatitis B**

Hepatitis B is a contagious liver disease that results from infection with the hepatitis B virus. Hepatitis B is spread when blood, semen, or another body fluid from a person infected with the virus enters someone who is not infected.

A person can become infected by the virus by activities such as sex with an infected partner; sharing drug-injection equipment; sharing items like razors and toothbrushes with an infected person; direct contact with open sores; and exposure to blood from needlesticks and other sharp instruments. The

	<p>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.</p> <p>The best way to prevent Hepatitis B is by getting vaccinated. The CDC recommends the Hepatitis Vaccine for high risk individuals including residents and staff of residential and non-residential day facilities for persons with developmental disabilities .</p> <p><i>Source: CDC (2009)</i></p>	
<p><b><u>Standard 12</u></b> <b><u>Annual Physical Exam:</u></b> Annual physical exams are required for all individuals receiving services from DDA or their contracted agencies, unless otherwise documented, in writing, by the primary care physician.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA.</p>	<p><b>Annual Physical Exam</b></p> <p><b>Comprehensive Medical Service Delivery:</b> The medical needs of the individual should be addressed by the individual’s primary care provider. This can include a physician, nurse practitioner or physician’s assistant. Annually, the primary care provider should complete a thorough physical assessment as needed for the individual’s age, gender and general physical health and provide a summary of the assessment and any recommendations in writing. (See Medical Evaluation Form in Appendix.)</p> <p>Consultations with specialists will usually be ordered by the primary care provider, but any changes to the individual’s medical plan of care should be coordinated with the primary care provider. Documentation from the specialty consult must be shared with the primary care physician. The PCP in turn should document in writing that they have reviewed the results of these consults and any follow-up as recommended by the PCP. Any decision to decline a recommendation should also be documented including rationale.</p> <p>All laboratory and procedural reports should be obtained and placed with the individual’s record as quickly as possible. The primary care provider must be notified of any laboratory tests not within normal limits.</p> <p>Recommendations for general medical care, specialty care, and medical follow-up should be carried out by the residential service provider, within the time frame</p>	<p><b><u>Documentation:</u></b> Documentation of comprehensive health services including health assessments, lab, diagnostic, and screening tests, and specialty consultations will be maintained in the health record.</p>

	<p>prescribed by the physician and/or specialist.</p> <p>Annual medical assessments are to include:</p> <ul style="list-style-type: none"> <li>• All medical and psychiatric diagnoses</li> <li>• Current medications</li> <li>• Recent illness profile</li> <li>• History</li> <li>• Physical exam</li> <li>• Laboratory test results.</li> </ul> <p>The assessment is to be appropriate for the age and gender of the individual, and tailored to the special characteristics/needs of the individual.</p> <p>The following should be viewed as minimum guideline/standards and not as final goals.</p> <p>The assessment should include the following:</p> <ol style="list-style-type: none"> <li>1. Physician's name, signature and date</li> <li>2. Complete medical problems list</li> <li>3. Body systems review with blood pressure and weight; including review of ideal weight range</li> <li>4. Complete list of prescribed medications, including over-the-counter medication and any other alternative therapy used by the individual</li> <li>5. A list of lab, diagnostic or preventative screening tests in compliance with the US Preventative Health Task Force (See Health Form 1).</li> <li>6. Any recommendations made by the primary care provider</li> </ol> <p>The service coordinator will provide a list of medical providers for those who do not have a primary care physician.</p> <p><b>Suggestions to Prepare for the Annual Physical Exam:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The behavioral reaction of an individual to physical examinations needs to be considered. Strategies to ensure a successful physical exam</li> </ul>	
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	<p>should begin with educational and positive behavioral approaches before consideration of sedation.</p> <ul style="list-style-type: none"> <li>• Update the health passport and bring it to the appointment. Discuss the need for any screening tests.</li> <li>• Update Health Form 1 and bring it to the medical appointment so the primary care provider can determine what if any preventative health screenings are needed.</li> <li>• Review the immunization information on the health passport and discuss the need for updates with the primary care provider.</li> <li>• Copies of all reports from other physicians such as specialists, emergency room episodes, etc., should accompany the individual on the appointment for annual physical exam.</li> </ul> <p>Source:  Suggestions to Prepare for the Annual Physical Exam  - <i>Vermont Health and Wellness Guidelines (2004)</i></p>	
<p><b>Standard 13</b></p> <p><b><u>Dental Exam:</u></b>  Semi-annual dental examinations and cleanings (or as specified by the dentist) are required by DDA policy and recommended by the American Dental Association.</p> <p><b><u>Applies to:</u></b>  All individuals receiving services through DDA</p>	<p><b>Dental Exam</b></p> <p>Dental needs of individuals should be addressed by the individual’s primary dentist. A list of dental practitioners can be obtained from DDA service coordinators.</p> <p>The following are to be viewed as the minimal standards/guidelines for dental care, and not final goals:</p> <ol style="list-style-type: none"> <li>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</li> </ol>	<p><b><u>Documentation:</u></b>  Documentation of dental care and specialty consultations will be maintained in the health record.</p>

	<p>plan must be developed that outlines specific dental needs which require interventions, monitoring, or referral to a specialist.</p> <ol style="list-style-type: none"> <li>2. Radiographs (x-rays) are recommended one-to-two times per year for basic evaluation purposes, and as indicated by the dentist or dental specialist.</li> <li>3. Scaling/prophylaxis should be performed at least twice per year 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.</li> <li>4. One or two soft tissue evaluations are recommended for persons without natural teeth. Dentures should be evaluated for stability, retention, and function on these occasions. Additional visits may be required to adjust denture comfort on an as needed basis.</li> <li>5. Full mouth rehabilitation (comprehensive treatment of all existing dental needs) under general anesthesia for persons requiring this method of service, delivery is not recommended more than every three years.</li> </ol> <p>For individuals residing in ICF/IDDs and individuals served by the HCBW – dental services must be designated in the ISP and prior authorization for dental services must be obtained from the Department of Health Care Finance (DHCF). DDA service coordinators facilitate the process of securing prior authorization. Residential providers have a responsibility to ensure that these authorization requests occur in a timely manner.</p>	
<p><b><u>Standard 14</u></b> <b><u>Hearing &amp; Hearing Aids:</u></b> Individuals should receive hearing screening in accordance with the National Guideline</p>	<p><b>Hearing Screening &amp; Hearing Aids</b></p> <p>Hearing screenings are effective in identifying existing hearing and ear problems. The goal of screening is to detect normal versus abnormal hearing.</p> <p>For individuals with developmental disabilities, it is</p>	<p><b><u>Documentation:</u></b> Documentation of hearing screenings and audiological recommendations will be maintained in the health</p>

<p>Clearinghouse.</p> <p>Hearing aids, if prescribed, require ongoing maintenance for safe and effective use.</p> <p><b><u>Applies to:</u></b>  All individuals receiving services through DDA.  All individuals receiving services from DDA.</p>	<p>important to screen for the following reasons:</p> <ul style="list-style-type: none"> <li>• To identify individuals with developmental disabilities who are also hearing impaired.</li> <li>• To identify and treat otitis media or other conductive problems which are common in individuals with some developmental disabilities (i.e. Down Syndrome)</li> <li>• To determine if a hearing aid would improve the individual's functioning in cases where hearing loss is identified.</li> </ul> <p>Hearing screenings using conventional audiometry are recommended each year. However, screening procedures may require modifications for individuals with developmental disabilities. It is important to conduct hearing screenings in environments that are quiet, free from external noise, and without distractions.</p> <p>Prior to screening using an audiometer, auditory training tasks should be given to prepare the individual for testing. Training will help the individual with developmental disabilities accept wearing earphones. Attempts should be made to condition the individual to respond to stimuli presented from an audiometer. Often reconditioning is necessary at every screening level frequency.</p> <p>If an individual cannot condition within 10-15 minutes to respond to stimuli from an audiometer, speech-based screening procedures may be considered. For adults whose behavior within a hearing screening setting has been established, the speech-based screening procedures described below should be used.</p> <p>Speech-based screening procedures should include verbal commands that the individual would be familiar with (i.e. "touch your nose" or "stand up").</p> <p>If an individual is not able to carry out verbal commands, behavioral screening techniques may be appropriate. Body movements would be observed in response to a sound field test. When an object is activated for sound out of the individual's field of vision (i.e. bell ringing), any eye movement, head movement, smile, etc., should be noted.</p>	<p>record.</p>
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	<p>If an individual does not pass the screen, they should be referred for an audiological assessment and/or cerumen (ear wax) removal if there is otoscopic identification of impacted cerumen</p> <p>A professional audiological assessment is also indicated for older adults if:</p> <ul style="list-style-type: none"> <li>• Behavioral changes are noted.</li> <li>• Hearing loss interferes with quality of life.</li> <li>• Hearing loss is accompanied by an earache, a discharge from the ears, or tinnitus (a ringing in the ears, dizziness or balance problems).</li> </ul> <p>Documentation of any hearing screens must be maintained in the person’s file on Health Form 1, along with any prescriptions for hearing aids.</p> <p>It is the responsibility of the interdisciplinary team to determine appropriate levels for screening taking into consideration the individual’s use of sound in day-to-day communication. For example, before an invasive procedure such as Brain Stem Evoked Response, consider the individual’s day-to-day ability to enjoy music, listen to conversations, and observing their living environment to assess if testing is needed.</p> <p>Sources:  <i>American Speech-Language-Hearing Association Guidelines for Adult Screening, 2009</i>  <i>American Speech-Language-Hearing Association, 1997</i></p> <p>Hearing Aids  Individuals 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 trouble-shooting problems accompany the owner’s manual and need to be available for reference.</p> <p>Regular and routine checks of the hearing aids, including battery checks and changes, are needed.</p>	
<p><b>Standard 15</b></p> <p><b><u>Vision/Eye Health Care:</u></b>  Individuals should</p>	<p><b>Vision/Eye Health Care</b></p> <p>Visual problems are more in common in adults with intellectual disabilities, but they are also less likely to report changes. Vision problems may have a disproportionate impact on adults who rely on</p>	<p><b><u>Documentation:</u></b>  Documentation of vision screening</p>

<p>receive vision screening and glaucoma exams in accordance with the USPFTF Guidelines.</p> <p><b><u>Applies to:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p>sensory input to compensate for some of their intellectual disabilities.</p> <p>For adults 19 years of age or older a vision screen is recommended every year. A visual acuity screen can be conducted by a registered nurse or an optometrist. Ophthalmologists are typically consulted on matters related to eye disease such as glaucoma and cataracts. If an individual reports changes or behavioral changes may be attributed to visual acuity, a re-screen should be completed immediately.</p> <p>The following schedule is recommended for glaucoma screening:</p> <ul style="list-style-type: none"> <li>• 19-39 years: Every 3-5 years in high risk patients. At least once in patients with no risk factors.</li> <li>• 40-64 years: Every 2-4 years</li> <li>• 65+: Every 1-2 years.</li> </ul> <p>Glaucoma screening can be completed by an optometrist. Visual acuity exams and glaucoma screenings should be noted on Health Form 1.</p> <p>The service coordinator is responsible for monitoring and insuring that follow-ups and recommendations are completed as required.</p>	<p>will be maintained in the health record.</p>
<p><b><i>Standard 16</i></b></p> <p><b><u>Immunizations:</u></b> Individuals will receive immunizations according to the CDC Adult Immunization Schedule for adult immunizations. Immunization records are to be maintained in the individual's file as part of the Health</p>	<p><b>Immunizations</b></p> <p>Immunizations for vaccine-preventable diseases are vital for the health and safety of adults. Immunization decisions should be based on the Centers for Disease Control and Prevention Adult Immunization Schedule Recommendations, in conjunction with the individual's primary medical care provider. It is essential to check for updates or changes to the Schedule Recommendations.</p> <p>A current copy of the "Vaccine Administration Record for Adults" needs to be maintained as part of the Health Passport in the individual's health record.</p> <p>The Adult Immunization Schedule Recommendations include:</p>	<p><b><u>Documentation:</u></b> Immunization documentation will be maintained on an immunization record form as part of the <i>Health Passport</i>.</p>

<p>Passport.</p> <p><b><u>Applies to:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<ul style="list-style-type: none"> <li>• Tetanus (Td) – Td booster every 10 years.</li> <li>• Human Papillomavirus (HPV) – Recommended for females aged 11-26 years, prior to exposure to sexual activity.</li> <li>• Varicella – All adults without evidence of immunity to varicella should have evidence of 2 doses of single-antigen vaccine, unless they have a medical contraindication.</li> <li>• Herpes Zoster – A single dose of zoster vaccine is recommended for adults over age 60 years, unless they have a medical contraindication.</li> <li>• Measles, Mumps, and Rubella (MMR) Vaccine – Adults born during or after 1957 should have evidence of one or more doses of MMR, unless they have a medical contraindication.</li> <li>• Influenza (Flu) Vaccine – One dose each year is recommended for adults with chronic medical conditions and residents in long-term care and assisted living facilities.</li> <li>• Pneumococcal (PPSV) Vaccine – One or two doses are recommended for adults with chronic medical conditions, and adults living in long-term care facilities.</li> <li>• Hepatitis B – Three doses are recommended for all high risk adults including those with developmental disabilities residing in institutional settings.</li> </ul> <p>Source: <i>CDC Advisory Council on Immunization Practices, MMWR Weekly, January, 2009, 57(53).</i></p>	
<p><b><i>Standard 17</i></b></p> <p><b><u>Medication Prescription &amp; Administration:</u></b> All individuals will receive or self-administer medications in a safe and timely manner in home and community settings.</p>	<p><b>Medication Prescription and Administration</b></p> <p><b>Note: See additional information in Section 18 that specifically addresses Psychotropic Medications.</b></p> <p><b>Medication Prescription</b></p> <p>1. Medication orders must include the name of the individual, name of the medication, name and telephone number of the licensed health care practitioner, time of administration, dosage, method of administration, and duration of medication. 2. All prescription medications, not including psychotropic medications used for behavioral purposes, are reviewed and renewed annually at the time of the</p>	<p><b><u>Documentation</u></b> Medication administration will be documented in the MAR (Medication Administration Record) for individuals residing in ICF/IDD.</p>

<p><b><u>Applies to:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p>	<p>annual physical exam or as indicated by the physician or practitioner. Prescriptions for psychotropic drugs must be re-prescribed every 30 days.</p> <p>3. A change in medication dosage requires a new prescription with a written order by the licensed physician/practitioner.</p> <p>4. Only a licensed nurse shall accept a telephone medication order from a licensed physician/practitioner for a new prescription or change in dosage or frequency.</p> <p>5. PRN medications are medications that are ordered by the physician /practitioner to be administered on an “as needed” basis according to specific written parameters by the physician/practitioner. Parameters must include the reasons for administration, the time/frequency to which administer the medication, conditions under which to administer the medication, conditions under which the prescribing practitioner should be notified i.e. medication is not effective and/or the individual’s symptoms are growing more severe.</p> <p>6. For individuals taking prescription medications, all other medications, including over-the-counter medication, must also be approved by the physician/practitioner. The pharmacist should be informed of any over-the-counter medications because they may interact with prescription medications.</p> <p>7. All medications and dosages should be checked for accuracy at the time of purchase.</p> <p>8. The supervisory registered nurse, for the individual’s program, shall obtain and maintain on file at the program’s facility and where the individual most often receives medications, instructions written by the licensed practitioner to include the name and strength of medication; name and telephone number of prescribing physician/practitioner time, dosage, method of administration, and duration of medication; compatibility with other prescribed and non-prescription medications; known program participant allergies; medication usage warnings; side effects;</p>	
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	<p>and other potential adverse reactions.</p> <p>9. A current list of medications including the diagnoses and/or symptoms for which medications are prescribed must be documented on the both the Medication Administration Record (MAR) and the <i>Health Passport</i>.</p> <p><b>Medication Administration</b></p> <p>1. All medications must be administered as ordered. Medication administration records (MAR) are required for all individuals 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.</p> <p>2. If medication errors occur, the nature of the error is to be documented with a critical incident report.</p> <p>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.</p> <p>4. Prescription PRN medications require assessment by a nurse or the prescribing physician/practitioner prior to its administration by a Trained Medication Employee.</p> <p>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.</p> <p>6. The supervisory registered nurse shall review practitioner's orders, MAR and medication intervals for all program participants on a monthly basis.</p> <p><b>Self-medication</b></p> <p>Individuals, who indicate the desire and possess capabilities, may administer their own medications.</p>	
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	<p>An assessment based on recognized standards for self-medication should be used, with any accommodations needed by the individual specifically noted.</p> <p>A registered nurse must assess knowledge and skills, monitor self-administration of medications, and determine the frequency of review/reassessment. Documentation of this assessment is required if the agency has a role in health services. Source: <i>DC Code 21-1202</i></p> <p>Service Coordinators can consult with DDA Health and Wellness nurses if assistance is needed for self-medication assessment.</p> <p><i>For information on self-medication, see Self-Medication Assessment Tool in Appendix.</i></p> <ol style="list-style-type: none"> <li>1. For individuals who self-administer medication, a basic record of medication documentation will be maintained in the home.</li> <li>2. Direct care staff will not administer medications, but may offer a reminder to individuals when it is time to self-administer.</li> </ol> <p><b>Training and Monitoring</b> Trained Medication Employees (TMEs) are individuals who have successfully completed a medication administration course approved by the District of Columbia Board of Nursing, and are certified to administer medications to program participants.</p> <ol style="list-style-type: none"> <li>1. TMEs are supervised by registered nurse on an ongoing basis. The supervisory registered nurse shall be available to the TME for general or direct supervision.</li> <li>2. Prior to administering medication to a program participant, all TMEs shall: <ul style="list-style-type: none"> <li>• Observe a registered nurse administering medication on at least two (2) occasions</li> <li>• Be observed by a registered nurse on at least four (4) separate occasions</li> <li>• Demonstrate proficiency and knowledge for all</li> </ul> </li> </ol>	
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	<p>program policies pertaining to medications</p> <ul style="list-style-type: none"> <li>• Demonstrate knowledge of medications to be administered</li> </ul> <p>3. A registered nurse shall observe, review, and evaluate in writing the ability of the TME to properly administer, document, and store medication for a program participant every three (3) months for the first year of certification and every six (6) months thereafter.</p> <p>4. Any first dose of a medication must be administered by a licensed practical or registered nurse.</p> <p>5. The supervisory registered nurse is responsible for ongoing monitoring of all people who administer medications to insure safe medication administration practices - documentation of this monitoring is required. (DC Board of Nursing Delegation</p> <p>Source: <i>DC Code 21-1201-12061 and the DC Municipal Regulations for Trained Medication Employees (TMEs).</i></p>	
<p><b>Standard 18</b></p> <p><b><u>Psychotropic Medications:</u></b> 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 individuals will have appropriate access to information and treatment with psychoactive medications, and</p>	<p><b>Psychotropic Medications</b></p> <p>Psychotropic medications when used should strive to find a minimal effective dose, and be part of an overall treatment strategy that includes psychosocial treatment interventions. These interventions include the identification and management of stressors, changes needed in the environment, teaching individuals and caregivers and other treatment approaches such as cognitive-behavioral therapy.</p> <p>DDS has adopted the following standards:</p> <ul style="list-style-type: none"> <li>• A licensed, board-certified psychiatrist must make all decisions: a) if an individual should undergo a formal assessment for an Axis I mental disorder; b) if the individual is likely to benefit from taking a psychotropic medication; and c) the prescription, administration, monitoring, and oversight of such medications.</li> <li>• Psychotropic medication shall only be</li> </ul>	<p><b><u>Documentation:</u></b> The psychotropic drug review form will be used to document the interdisciplinary review of prescriptions for psychotropic medications.</p> <p>The critical incident report will be completed when medications are administered on a one-time basis to address a psychiatric health problem.</p>

<p>shall have reasonable protection from serious side effects or the inappropriate use of these medications. (Source: DDS Policy 6.5)</p> <p><b><i>Applies to:</i></b> All DDS employees, providers/vendors, community representatives, government entities and individuals who provide support or services to individuals receiving services and supports from DDA.</p>	<p>prescribed to individuals with developmental disabilities who have a formal psychiatric assessment and an Axis I diagnosis of mental disorder. Documentation from the provider will be required acknowledging the psychiatric assessment recommendations for psychotropic medication use for the individual. The plan must be incorporated into the ISP, and a behavioral support plan will be in place prior to the prescription of the medication(s).</p> <ul style="list-style-type: none"> <li>• The concept of “minimal effective dose” (MED) needs to be reflected in medication orders. This term refers to use of the lowest dose of medication that produces the desired effect.</li> </ul> <p>I. Prescribing practitioners shall assess individuals for abnormal movement disorders as follows:</p> <ul style="list-style-type: none"> <li>A. Any individual not currently taking a neuroleptic medication shall receive a baseline screening under the following circumstances: <ul style="list-style-type: none"> <li>a. upon recommendation for treatment with neuroleptic medication, prior to the administration of the drug or</li> <li>b. upon admission to a DDS operated, funded, or licensed facility or program if the individual has a recent <b><u>history (i.e. within the last 6 months)</u></b> of previously taking neuroleptic medication.</li> </ul> </li> <li>B. All individuals currently taking a neuroleptic medication shall be assessed at least once every six months or more frequently as necessary by symptom assessment or determined by the prescribing practitioner.</li> <li>C. Any individual currently taking a neuroleptic medication who is newly admitted to a DDS operated, funded, or licensed facility shall have an initial screening within one month of admission.</li> <li>D. Any individual whose neuroleptic medication is discontinued shall be</li> </ul>	
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	<p>screened after the discontinuation at the following intervals:</p> <ol style="list-style-type: none"> <li>a. one month</li> <li>b. three months, or</li> <li>c. whenever the prescribing practitioner determines and documents that the individual does not have TD</li> </ol> <p><b>NOTE:</b> In rare instances withdrawal movement disorders can emerge after three months following the discontinuation of a neuroleptic. This is more apt to occur following the use of a long acting, injectable neuroleptic. If movements are observed after the three-month screening, the individual should be referred to the prescribing practitioner for assessment.</p> <ol style="list-style-type: none"> <li>II. All screenings and/or prescribing practitioner assessments, diagnoses and treatment plans shall be documented in the individual's medical record.</li> <li>III. Individuals 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.</li> <li>IV. When an individual is diagnosed with TD, the following shall occur: <ol style="list-style-type: none"> <li>A. Documentation of the diagnosis on Axis III.</li> <li>B. The prescribing practitioner shall notify the individual's service coordinator or nurse of the diagnosis and treatment recommendations.</li> <li>C. The service coordinator or nurse shall notify the individual's treatment team, family or guardian, advocate, and the DDS.</li> <li>D. The treatment team shall meet within 30 days of the notification and shall ensure that all appropriate recommendations are provided and documented in the individual's health file.</li> </ol> </li> </ol>	
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	<p>V. If an individual is diagnosed with tardive dyskinesia (TD), the treatment team including the prescribing practitioner, shall examine the risk versus benefit for this individual and consider the necessity for continuing the medication.</p> <p>A. When a decision is made to discontinue or reduce a neuroleptic medication, the treatment team will be informed of the recommendations for dose reductions and discontinuation of the neuroleptic.</p> <p>B. When a decision is made not to reduce or discontinue the neuroleptic medication, the treatment team must ensure that documentation details the following:</p> <ul style="list-style-type: none"> <li>a. the risks versus benefits of continuing the neuroleptic medication and</li> <li>b. the consent for the medication clearly states that the individual will continue to take the medication even though TD has been diagnosed.</li> </ul> <ul style="list-style-type: none"> <li>• An interdisciplinary 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 individual's clinical status.</li> <li>• Psychotropic medications must be renewed by a physician or nurse practitioner every 30 days.</li> <li>• The psychotropic medication review form should be used to document Axis 1 diagnoses, labs, status of current health concerns, side effect monitoring, and medication changes.</li> <li>• For one-time basis medications, the name and dosages of medications given on the one-time basis for the purpose of addressing a psychiatric illness as defined in a behavior support plan must be documented with a <u>critical incident report</u>. The incident report shall include a description of the person's behaviors as well as documentation of less intrusive interventions tried prior to medication administration. Follow-up by supervisory staff must occur.</li> </ul>	
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	<p>Please refer to the Appendix for:</p> <p><b>“A CHECKLIST FOR COORDINATORS AND SUPERVISORS: Psychiatric and Behavioral Problems in Individuals with Intellectual Disability”.</b></p> <p>This checklist is based on <b>“Treatment of Psychiatric and Behavioral Problems in Individuals with Mental Retardation: An Update of the Expert Consensus Guidelines”</b> by MC Aman, ML Crismon, A Frances, B H King and J Rojahn. The checklist, which was based on the recommendations of a panel of national experts, was developed for Service Coordinators, Program Managers, QDDP’s and others who coordinate and supervise care for individuals with intellectual disability. It was adapted from the guidelines with permission of the publisher.</p> <ul style="list-style-type: none"> <li>• Source: <i>DDS Policy</i></li> <li>• Behavior Support Policy and Procedures</li> <li>• Human Rights Policy</li> <li>• Human Rights Advisory Committee Procedure</li> <li>• Restrictive Control Review Committee Procedures</li> </ul>	
<p><b>Standard 19</b></p> <p><b><u>Psychiatric Services:</u></b> Psychiatric assessment and treatment will be available for individuals with known or suspected psychiatric disorders. Licensed psychiatrists will provide assessment, diagnosis and treatment of psychiatric disorders.</p>	<p><b>Psychiatric Service</b></p> <p>Psychiatric services, like all other specialty services need to be coordinated within the framework of an interdisciplinary team, including the primary care physician. For psychiatric care to be effective, strong communication must be maintained so that the prescribing psychiatrist has the complete data from which to make an accurate diagnosis, plan for treatment (including non-pharmacologic approaches), assess for the effectiveness of prescribed medications, and to assess for deleterious side effects.</p> <p>Interdisciplinary teams need a uniform way of documenting the review of behavioral and laboratory data as well as screening for side effects. DDA recommends the adoption of the universal Psychotropic Review Form (See Appendix.)</p>	<p><b><u>Documentation:</u></b> Psychiatric services will be documented in the physician progress notes, consultation forms, and the psychotropic medication review form.</p>

<p><b><u>Applies to:</u></b> All individuals receiving services through DDA</p>		
<p><b><i>Standard 20</i></b></p> <p><b><u>Therapeutic Services:</u></b> Therapeutic services, such as physical therapy, occupational therapy, and speech/language therapy services, are to be supported by evidenced-based practice.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA.</p>	<p><b>Therapeutic Services: Physical, Occupational, and Speech &amp; Language Therapies</b></p> <p>Evidence based practice therapeutic services include the integration of the best available research, clinical expertise, and patient values and circumstances related to client management (American Physical Therapy Association, 2009).</p> <p><b>Physical Therapy</b> Physical therapy services are available to diagnose, manage, and treat disorders of the musculoskeletal system. Physical therapists work with individuals to address problems with ambulation, balance, positioning, and loss of functional independence. The goal of physical is to restore maximal functional independence.</p> <p><b>Occupational Therapy</b> Occupational therapy services are available to assist individuals with the development, recovery, or maintenance of daily living and work skills. Occupational therapists work to support an individual's ability to engage in everyday activities and acquire new skills to promote function. The goal of occupational therapy is to assist individuals in developing independent, productive, and satisfying lives.</p> <p>To be eligible for reimbursement, Physical therapy and Occupational therapy services must be:</p> <ul style="list-style-type: none"> <li>• Ordered by an individual's primary care physician or practitioner</li> <li>• Be reasonable and necessary for the treatment of the individual's illness, injury, or long-term disability</li> <li>• Be included in the ISP</li> </ul> <p>The physical therapist and/or occupational therapist, at a minimum, will:</p> <ul style="list-style-type: none"> <li>• Prepare a report summarizing the physician order,</li> </ul>	<p><b><u>Documentation:</u></b> The physician order for therapeutic services needs to be maintained in the Health Record.</p> <p>Written documentation by therapists in the forms of reports, assessments, visitation notes, and progress notes are to be maintained in the Health Record.</p>

	<p>measures of strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor functions.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Maintain ongoing involvement and consultation with other service providers and caregivers</li> <li>• Ensure the individual's needs are met in accordance to the physician order</li> <li>• Provide consultation and instruction to the individual, family, and/or other caregivers</li> <li>• Record a progress note on each visit</li> <li>• Conduct periodic examinations modifying treatments for the individual, when necessary</li> <li>• Provide written documentation of the person's progress or lack of progress, medical conditions, functional losses and treatment goals that demonstrate that physical therapy services are reasonable and necessary.</li> </ul> <p>Source: <i>District of Columbia DCMR Title 29, Chapter 9, Section 934 (Physical Therapy) and 935 (Occupational Therapy)</i></p> <p><b>Speech and Language Services</b></p> <p>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.</p> <p>To be eligible for reimbursement, speech, hearing, and language services must be:</p> <ul style="list-style-type: none"> <li>• Ordered by a physician if the individual has any history of aspiration, swallowing problems, tube feedings, or other medical issues</li> <li>• Recommended by the interdisciplinary team if the issues are not medical</li> </ul>	
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- Be reasonable and necessary for the treatment of the individual's illness, injury, or long-term disability
- Be included in the ISP

Speech, hearing, and language services may be used to:

- Address swallowing disorders
- Assess communication disorders
- Assess potential for clearer speech
- Assess potential for use of augmentative and alternative speech devices, methods, or strategies
- Assess potential for sign language or other expressive communication methods
- Conduct environmental reviews of communication in places of employment, residence, or other sites
- Assist with recovery from a vocal disorder
- Speech, language, and hearing services shall include, as necessary, the following:
  - A comprehensive assessment to determine the presence or absence of a swallowing disorder
  - A comprehensive assessment of communication disorders
  - A background review and current functional review of communication capabilities in different environments
  - A needs assessment for the use of augmentative and alternative speech devices, methods, or strategies
  - A needs assessment for use of adaptive eating equipment
  - Assist persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production
  - Aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss

The speech, hearing, and language service provider will be responsible for providing:

- Written documentation in the form of reports, assessments, physician orders, visitation notes, progress notes, and other

	<p>pertinent documentation of the individual's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the services are and continue to be reasonable and necessary.</p> <p>Source: <i>District of Columbia DCMR Title 29, Chapter 9, Section 932 (Speech, Hearing, and Language Services)</i></p>	
<p><b>Standard 21</b></p> <p><b><u>Seizure Disorders and Protocols:</u></b> Individuals will be appropriately screened for the presence of seizure disorders and receive timely and comprehensive care coordinated by the primary care provider in consultation with neurologists and other specialists.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA</p>	<p><b>Seizure Disorders and Protocols</b></p> <p>Seizure Disorders or epilepsy is the most common comorbid medical condition in individuals with developmental disabilities. The incidence of epilepsy is related to the severity of the intellectual involvement with a rate of 20% in individuals with mild intellectual impairment, and can be as high as 50% in individuals with severe-to-profound intellectual disabilities (Alvarez, 2008).</p> <p>Most people with seizure disorders are followed by a neurologist on a time-table prescribed by the neurologist. When an individual attends a neurology consultation they should bring with them:</p> <ul style="list-style-type: none"> <li>• a record of seizures from the time of the last appointment</li> <li>• The health passport noting any changes in medications or diagnoses</li> <li>• Any data reporting recent behavioral changes</li> </ul> <p><b>New Onset Seizures</b> New onset seizures require a medical evaluation, and imaging studies, laboratory tests, and EEG. Individuals with developmental disabilities are living longer than before; therefore the incidence of new-onset seizures is high in individuals over 60 years of age.</p> <p>In the situation of new onset seizures - trauma, tumors, and infections need to be considered. In individuals in their late 40's with Down Syndrome, seizures may be seen as an expression of Alzheimer disease (Alvarez, 2008).</p> <p><b>Situations Requiring Medical Evaluations</b> Other situations that would be considered an emergency requiring medical evaluation include:</p>	<p><b><u>Documentation:</u></b> 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.</p>

	<ul style="list-style-type: none"> <li>• Seizures that do not stop within five minutes (See Status Epileptics below)</li> <li>• The person’s post-ictal or post-seizure behavior is significantly different than their usual post-ictal state</li> <li>• The person has difficulty breathing</li> <li>• The person was injured during the seizure</li> <li>• The seizure is a first-time seizure</li> <li>• There is a significant change in the type or character of the seizure from that person’s usual seizure pattern</li> </ul> <p>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)</p> <p>The most common precipitating factor for SE is a change in medication – either abrupt cessation of medication (i.e. being placed on NPO “nothing by mouth” before a medical procedure or medication not be administered) or non-adherence to seizure medication regimen (Spitz, Lum, &amp; Cavazos, 2007).</p> <p>A written seizure record needs to be maintained on all individuals with seizures. A complete seizure record consists of the following information:</p> <ul style="list-style-type: none"> <li>• Date of seizure</li> <li>• Time of seizure</li> <li>• Antecedent to the seizure</li> <li>• Description of the seizure</li> <li>• Duration of the seizure</li> <li>• Post seizure status</li> </ul> <p>Care provided during and after the seizure activity</p>	
<p><b>Standard 22</b> <b><u>Nutrition:</u></b> Individuals will receive appropriate</p>	<p><b>Nutrition</b></p> <p>Good nutrition is a vital part of each individual’s quality of life. Individuals should be guided in</p>	<p><b><u>Documentation:</u></b> The physician order for nutrition</p>

<p>supports to access food that provides for adequate nutrition and offers a variety of foods for which the individual has indicated a preference.</p> <p><b><u>Applies to:</u></b> All individuals receiving services through DDA</p>	<p>learning about the components of a healthy diet, keeping in mind an individual’s personal, cultural and ethnic preferences. Many resources exist in the community to educate individuals and their support team. Examples include: community education courses at recreation centers, senior centers, churches, and hospitals.</p> <p>For underweight, overweight or obese individuals, interventions to promote and sustain optimal weight should be discussed with the individual’s primary care physician. 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.</p> <p>All support team members must be aware of the dietary protocol and the effectiveness of the diet should be tracked by weight charts and meal time diary.</p> <p>Weight records are kept for an individual if a need is determined by the Health Management Care Plan or a primary care provider order (e.g., underweight or overweight, to track chronic weight maintenance; for medications and/or treatments which may affect weight changes, etc.).</p> <p>Individuals 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 insure maintenance of adequate weight range.</p> <p>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 insure accuracy.</p> <p>ICF-IDD regulations require a minimum of quarterly evaluations by a registered dietician. For individuals living independently service coordinators must be aware during their monthly visits of changes to the individual’s nutritional habits or weight. If obvious changes are apparent in weight, the individual should</p>	<p>services needs to be maintained in the Health Record.</p> <p>Written documentation by dietician or nutritionist in the forms of reports, assessments, visitation notes, and progress notes are to be maintained in the Health Record.</p> <p>Weight logs are a part of the nutritional record and should be maintained along with other nutritional information in the Health Record. The frequency of weight measurements is determined by the nutritional services provider, physician, and/or registered nurse.</p>
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	<p>be referred to the primary care provider (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.</p> <p>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.</p> <p>Note: ICF-IDD regulations stipulate that only licensed dietitians can provide services. This excludes nutritionists. The HCBS Waiver, however, does fund both licensed dietitians and nutritionists.</p>	
<p><b>Standard 23</b></p> <p><u>Adaptive Equipment:</u></p> <p>All people who are supported by DDA shall receive an initial and ongoing assessment of their need for adaptive equipment.</p> <p>Modifications or repair of adaptive equipment will occur in an expeditious manner.</p> <p><b>Applies to:</b> All people supported by DDA.</p>	<p><b>Adaptive Equipment</b></p> <p><u>Background</u></p> <p>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.</p> <p>As with all decisions about a person's life, decisions about adaptive equipment should be directed by the person with information and support, as needed, from his or her support team. These should also be reflected in the person's Individual Support Plan (ISP).</p> <p>Adaptive Equipment includes both durable medical equipment (DME) and assistive technology (AT) devices.</p> <ul style="list-style-type: none"> <li>• DME includes items such as wheelchairs, hospital beds, toilets aides/commodos, canes, walkers, crutches, and other equipment that used in the person's home, capable of repeated use, and necessary to address the person's medical or physical need.</li> </ul>	<p><b>Documentation:</b> Orders for adaptive equipment and DME need to be noted in the PCP orders.</p> <p>For the adaptive equipment monthly checklist and tracking, please use the system in MCIS.</p>

- 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 health care professional (i.e. physical therapist, occupational therapist, speech/language clinician, or physician) when any new adaptive equipment needs are identified.

Additionally, a person who uses a custom wheelchair will always need an assessment by a health care 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 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

	<p>identified.</p> <p><u>Provider and Service Coordination Responsibilities</u></p> <p>Each provider staff member who supports a person with a disability must be familiar with all of the adaptive equipment that the person may use. It is the responsibility of Direct Support Professionals, Qualified Developmental Disability Professionals, Program Coordinators, nurses and other therapists to support the person to use and maintain 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.</p> <p>It is the responsibility of the residential provider, if a person has one, to ensure acquisition, repair and/or replacement of adaptive equipment. For people who live independently or with their family, the person’s Service Coordinator, in collaboration with the person and/his or her support network, is responsible for ensuring acquisition, repair and/or replacement of adaptive equipment.</p> <p>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 this be included within employee’s position description.</p> <p>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.</p> <p><u>Process for Submitting Adaptive Equipment Claims</u></p> <p>For people who receive supports through the Home</p>	
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	<p>and Community Based Services waiver, all adaptive equipment claims (custom and non-custom must be submitted to the insurance company. For people who live in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID), the provider is responsible for purchasing all needed non-custom adaptive equipment (<i>e.g.</i>, standard wheelchairs, shower chairs, hospital beds, hoist lifts, etc.). ICF/IID providers are required to bill the person's insurance for custom adaptive equipment (<i>e.g.</i>, custom wheelchairs, eyeglasses, dentures, etc).</p> <p>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.</p>	
<p><b>Standard 24</b></p> <p><b><u>End of Life Planning:</u></b> End of life planning is discussed within the context the annual ISP meeting.</p> <p><b><u>Applies to:</u></b> All individuals served by DDA.</p>	<p><b>End of Life Planning</b></p> <p>End of life decision making is not a single event that occurs in the midst of a critical illness. It is an on-going series of choices based on life experiences, family and friend support systems, as well as health issues (King and Craig, 2004).</p> <p>As an individual's life progresses or as changes occur in a person's health condition, opportunities arise for discussions with the individual 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 individual and their health care decision-maker need to decide the extent to which they are comfortable in planning. The interdisciplinary team has an obligation to introduce the topic, provide resources for developing plans, but it must be recognized that some individuals will choose to forgo this process.</p>	<p><b>Documentation:</b> End of life discussions, sharing of resources, and end of life plans must be documented in the Health Record and ISP. This may include meeting minutes that address of end-of-life issues.</p>

	<p><i>Additional information on End-of-Life planning can be found in the Appendix – see “Thinking Ahead”.</i></p>	
<p><b>Standard 25</b></p> <p><b><u>Alternative/Complementary Therapies:</u></b> The primary care physician needs to be consulted prior to the initiation of alternative/complementary therapies.</p> <p><b><u>Applies to:</u></b> Individuals residing in ICFs-IDD.</p> <p>Individuals enrolled in a Home and Community Based Waiver receiving residential habilitation, supported living, and host home services.</p> <p><b><u>Recommended for:</u></b> <i>Individuals living independently or residing in their family home.</i></p>	<p><b>Alternative/Complementary Therapies</b></p> <p>All alternative and complementary therapies need the input of the primary care physician prior to implementation.</p> <p>Alternative and complementary healthcare and medical practices are those that are not currently an integral part of conventional healthcare. Conventional healthcare refers to medicine as practiced by individuals who hold a medical doctor (MD) or doctor of osteopathy (DO) degree.</p> <p>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 primary care physician. This documentation must be kept in the individual’s file.</p>	<p><b>Documentation:</b> All alternative and complementary therapies should be documented in the health record and on the Health Passport.</p>